Baptist Memorial Hospital – Memphis and
Church Health
Family Medicine Residency Program

Program Handbook
2018 - 2019

UPDATED August 2018
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Incoming Resident Orientation:

Day One
- Baptist Orientation
- Luncheon
- Baptist Badges, Photos, Tour, etc.

Day Two
- Church Health Orientation including Mentor and Clinic Assignments

Subsequent Days to be Scheduled and will include the following:

- Patient Care
  - Competency Training and Assessment (including simulations)
  - OB Boot Camp (including simulations)
  - Clinic Assignments (1 day/ week during PGY-1)

- Medical Knowledge
  - Evaluation through previous ITE
  - ACLS, ALSO, AWHONN, NRP, PALS training (BLS if necessary)
  - Didactic Day
  - Online annual competency modules

- Professionalism
  - Medical Ethics / Risk Management
  - Resident Health

- Systems-Based Practice (BMH / CH)
  - BMH Quality and Performance Improvement

- Practice-Based Learning & Improvement
  - Ambulatory Site, Clinics, Hospital Site Orientations
  - Introduction to Research

- Communication
  - EMR Training (BMH & CH)
  - Resident Support Group
INTRODUCTION

Institutional Profile

About Us

Baptist Memorial Health Care is an award-winning network dedicated to providing compassionate, high-quality care for patients. With 17 affiliate hospitals throughout the Mid-South, Baptist combines convenience with excellence of care—two reasons we have been named among the top health care systems in the country for several years.

The Memphis area’s largest not-for-profit health care system, Baptist offers a full continuum of care to communities throughout the Mid-South. The Baptist system, which consistently ranks among the top integrated health care networks in the nation, comprises 17 affiliate hospitals in West Tennessee, North Mississippi, and East Arkansas; more than 4000 affiliated physicians; Baptist Medical Group, a multispecialty physician group with more than 500 doctors; home, hospice and psychiatric care; minor medical centers and clinics; a network of surgery; rehabilitation and other outpatient centers; and an education system highlighted by the Baptist College of Health Sciences. The Baptist system employs more than 15,000 people. According to the Sparks Bureau of Business and Economic Research at the University of Memphis, Baptist Memorial Health Care’s annual economic impact is estimated at more than $2.6 billion.

Baptist Mission

In keeping with the three-fold ministry of Christ - Healing, Preaching and Teaching - BMHCC is committed to providing quality health care.

Baptist Vision

We will be the provider of choice by transforming the delivery of health care through partnering with patients, families, physicians, care providers, employers and payers; and by offering safe, integrated, patient-focused, high quality, innovative cost-effective care.

Baptist Values

- Compassionate Care and Service
- Teamwork and Trust
- Innovation and Excellence
- Respect for the Individual and the Value of Diversity
Our Medical Training Facilities

Family Medicine

Primary Teaching Facilities

Baptist Memorial Hospital – Memphis
706 Licensed Beds

Crosstown Building (rendering)
Church Health

Baptist Memorial Hospital – Collierville
81 Licensed Beds

Baptist Memorial Hospital for Women
140 Licensed Beds

Baptist Memorial Hospital – DeSoto
339 Licensed Beds

Baptist Reynolds Hospice House and Kemmons Wilson Center for Good Grief
24 Licensed Beds
Baptist Memorial Hospital-Collierville

Baptist Memorial Hospital-Collierville opened May 1, 1999. This full-service hospital has premier facilities including large patient rooms with the amenities of home. Medical services at the hospital include a sleep disorders center, outpatient rehabilitation, inpatient and outpatient surgery, a critical care unit, a full-service emergency room, inpatient and outpatient diagnostics, five surgery suites, 58 acute care beds, seven critical care beds and a six-bed critical care step-down unit.

The Baptist Collierville Women's Center offers women advanced technology in the detection of breast cancer close to home. Certified by the Food and Drug Administration and accredited by the American College of Radiology, the center offers screening and diagnostic mammograms, breast ultrasounds, cyst aspirations, biopsies, wire localizations and bone densitometry testing. Experienced board-certified female radiologists and certified mammography technologists concerned with patient comfort and early detection staff the center. Baptist Collierville also offers the technically advanced life-saving procedure called HeartScore™.

Baptist Memorial Hospital-Desoto

For a quarter of a century, Baptist DeSoto has given patients across northwest Mississippi a place to find quality, specialized care. Founded in 1988, we continue to be recognized for our quality outcomes. We were designated as a “top performing” hospital in 2011 by U.S. News & World Report and selected as the Hospital of the Year by the Mississippi Nurses’ Association in 2010.

With more than 1950 employees, our colleagues dedicate each day toward raising the standard in clinical excellence. It is our goal to not only treat the medical health conditions of those who entrust us with their care, but also be a trusted health care resource within the communities we serve. Please check out our upcoming events section of the website to see how you can participate in local health fairs and community projects Baptist is sponsoring.

Baptist Memorial Hospital-Memphis

The Baptist Memorial Hospital-Memphis campus includes the flagship hospital of the Baptist Memorial Health Care system. Opened in 1979, the hospital is located adjacent to the I-240 loop. Also located on the Baptist Memphis campus is the 30-bed Restorative Care Hospital. With almost 27,000 discharges, 55,000 emergency department visits and 14,000 surgeries in 2010, Baptist Memphis is one of Tennessee's highest volume hospitals.

The emergency department has 31 treatment suites staffed by 24-hour-a-day emergency physicians for the treatment of adults. It also has a separate, dedicated five-room pediatric treatment area staffed around the clock with in-house pediatric emergency physicians. The pediatric emergency room has relocated to the Spence and Becky Wilson Baptist Children’s Hospital, part of Baptist Memorial Hospital for Women.

The Baptist Heart Institute, located within Baptist Memphis, is dedicated to providing leading-edge cardiovascular research and treatment for heart patients. The Heart Institute, which measures 165,000 square feet, includes areas for cardiovascular procedures, cardiovascular surgical suites, heart catheterization labs, cardiovascular intensive care beds, a cardiac intervention unit, cardiac medicine units, a pre/post cath lab unit, electrophysiology labs, a heart transplant unit and a cardiovascular step-down unit. The Ford-Goltman Clinical Research Center, also located in the Heart Institute, is a specialized unit dedicated to providing care for clinical research patients.

Baptist Memphis also operates the Plaza Diagnostic Pavilion; an outpatient facility that handles approximately 6,000 outpatient visits a month and centralizes many of the hospital's outpatient services.

According to HealthGrades, Baptist Memphis has ranked in the top 10% nationally for cardiac surgery 7 years in a row.

The cardiac surgery program was ranked best in Tennessee in 2011. Baptist Memphis is the only hospital in West Tennessee with HealthGrades distinctions in cardiovascular or neuroscience. The health care ratings organization also ranked Baptist Memphis in the top 5 percent in the nation in these same areas.

12011 best-in-market certifications provided by HealthGrades, Inc., the nation’s leading third-party health care ratings, information and advisory services company whose mission is to help guide America to better health care. Market areas are defined on www.healthgrades.com.

Baptist Memorial Hospital for Women

Baptist Memorial Hospital for Women is the only freestanding women’s hospital in Memphis and one of only a handful of such hospitals in the country. Opened in 2001, Baptist Women’s Hospital offers labor and delivery, gynecological surgery,
a newborn intensive care unit (NICU) and the Comprehensive Breast Center and is a regional referral center for high-risk pregnancies, mammography diagnostics and urogynecology.

Designed to meet the needs of women at every stage of their lives, the 140-bed hospital is located adjacent to the Baptist Memorial Hospital-Memphis campus and has a 24-hour maternity ambulance entrance, 23 labor and delivery suites and 48 mother/baby rooms with a well-baby nursery. With more than 800 physicians and 330 clinical professionals on staff, Baptist Women's Hospital is well equipped to provide quality health care to women across the Mid-South.

Baptist Women's Hospital was one of only three hospitals in the nation the American Hospital Association recognized for its quality efforts. The Quest for Quality Prize™ honors organizations that are committed to enhancing quality of care, patient-centeredness, effectiveness, efficiency, timeliness and equity as the basis of a comprehensive, quality-oriented health care system and have made progress toward making this vision a reality that other hospitals can emulate.

**Spence and Becky Wilson Children’s Hospital**

The Spence and Becky Wilson Baptist Children's Hospital, part of Baptist Memorial Hospital for Women, is the home of our children’s hospital services. In November 2014, Memphians Spence and Becky Wilson made a major gift to further the growth of the pediatric hospital adjacent to Baptist Memorial Hospital for Women. In recognition of their gift, which will help further the growth of inpatient and outpatient services offered at the hospital, the facility is called the Spence and Becky Wilson Baptist Children's Hospital.

The hospital opened its 17,000 square-foot emergency room, which features 10 bays for patient care, and a 2,000 square-foot diagnostics area on January 28, 2015. The emergency department is staffed 24/7 with pediatric emergency medicine physicians, pediatric hospitalists and an array of other pediatric specialists, including the Baptist system's first pediatric general surgeon and a pediatric anesthesiologist.

The pediatric emergency room will provide care for a host of issues including broken bones; fever; sprains, strains and tears; dehydration; flu; respiratory illnesses; lacerations and more.

Other pediatric services, including a 12-bed inpatient unit, outpatient pediatric surgery and the Pediatric Eye Center will eventually transition to the four-story pediatric hospital. Led by renowned vitreoretinal specialist Dr. Jorge Calzada, the Pediatric Eye Center is the only clinic in the Mid-South that offers the full continuum of eye care from diagnosis to treatment to surgery to follow-up. Previously, patients in need had to travel several hours for specialized pediatric eye care.

**Baptist Reynolds Hospice House**

The Baptist Reynolds Hospice House is a 24 bed hospice facility offering inpatient care for patients and families who can no longer receive the necessary in-home care. Located on the campus of Baptist Memorial Hospital-Collierville, the Hospice House provides a tranquil, wooded setting and features a home-like environment. Offering a full-continuum of care, our specially-trained staff is available around the clock and is dedicated to improving the quality of life of our residents. Those staying at Baptist Reynolds Hospice House will have unparalleled access to our unique combination of medical, emotional, and spiritual care. Physicians, nurses, certified nursing assistants, social workers, grief counselors, chaplains, and volunteers work as a team for the patient and their loved ones.
Our Medical Services

Cardiology

Baptist Heart Institute

Baptist is the only health care system in the Mid-South that offers the full spectrum of heart care, from noninvasive cardiology to adult heart transplantation. The Baptist Heart Institute is designed to deliver comprehensive services to its patients in the most convenient way possible. It combines all heart services in one facility to support high-quality care, research, education and data management.

The Baptist Heart Institute includes: a surgery addition, cardiac catheterization labs, a pre- and post-cardiac patient staging area, heart transplant unit, cardiovascular recovery/cardiovascular intensive care unit, two cardiac medicine units and a cardiac intervention unit. The facility also includes a waiting area for patients' families and houses the Ford-Goltman Clinical Research Center, an inpatient facility that allows researchers to conduct several types of clinical research trials.

Through the Heart Institute, doctors, staff and patients have an increased awareness of and access to new treatments. In addition, doctors focus on research and new treatment options, which affect both the quality and length of life.

HealthGrades Recognition for Excellent Heart Care

HealthGrades has rated the Baptist Heart Institute as Tennessee's top-rated heart surgery program and in the nation's top 10 percent.*

HealthGrades compiles patient outcomes data from more than 70 independent sources, including the Centers for Medicare and Medicaid Services and state hospital and medical board records. HealthGrades risk-adjusts the data using advanced statistical techniques to make valid comparisons between providers; translates the data into easily understandable, objective ratings; and uses this information to assess and improve the quality of health care.

*C2011 best-in-market certifications provided by HealthGrades, Inc., the nation's leading third-party health care ratings, information and advisory services company whose mission is to help guide America to better health care. Market areas are defined on www.healthgrades.com.

Chest Pain Accreditation

Baptist DeSoto received its Chest Pain Center Accreditation from the Society of Chest Pain Centers (SCPC), an international not-for-profit organization that focuses on transforming cardiovascular care by bringing together quality, cost and patient satisfaction.

Hospitals that have received SCPC accreditation have achieved a higher level of expertise in dealing with patients who arrive with symptoms of a heart attack. Criteria include standardized diagnostic and treatment programs that provide more efficient and effective evaluation as well as more appropriate and rapid treatment of patients with chest pain and other heart attack symptoms.

To become an Accredited Chest Pain Center, Baptist DeSoto engaged in rigorous evaluation by SCPC for its ability to assess, diagnose, and treat patients who may be experiencing a heart attack. To the community served by Baptist DeSoto, this means that processes are in place that meet strict criteria aimed at:

- Reducing the time from onset of symptoms to diagnosis and treatment
- Treating patients more quickly during the critical window of time when the integrity of the heart muscle can be preserved
- Monitoring patients when it is not certain that they are having a heart attack to ensure that they are not sent home too quickly or needlessly admitted to the hospital
- Baptist DeSoto's advanced health care encompasses the entire continuum of care for the heart patient and includes such focal points as dispatch, Emergency Medical System, emergency department, cath lab, Baptist DeSoto's quality assurance plan, and its Strong HEARTS community outreach program. By becoming an Accredited Chest Pain Center,
Baptist DeSoto has enhanced the quality of care for the cardiac patient and has demonstrated its commitment to higher standards.

Hospice

Baptist Reynolds Hospice House and Kemmons Wilson Family Center for Good Grief

Our House is Your House

**Hospice House**

When a life-limiting illness is no longer manageable at home, the Baptist Reynolds Hospice House can provide much-needed comfort and support to patients and their loved ones. The Hospice House is located on the campus of Baptist Memorial Hospital-Collierville. The residence is located in a tranquil, wooded setting and features a home-like environment with 24 private rooms. Offering a full-continuum of care, our specially-trained staff is available around the clock and is dedicated to improving the quality of life of our residents.

Services include:

- A home-like environment featuring spacious, private patient rooms which open to individual outdoor patios
- Patient spa
- Home-cooked meals, prepared on-site
- Large living room areas with three fireplaces
- Children's play room
- Interfaith chapel
- Internet Café and wireless Internet throughout the House
- Beautiful outdoor gardens
- Pet and music therapy

Coping with Loss and Grief

**Grief Center**

As the first comprehensive bereavement center for children, adolescents and adults in the region, the Kemmons Wilson Family Center for Good Grief provides support for individuals who are grieving the death of a loved one and allows them to share their experience with others as they move through the healing process—all in a therapeutic environment. Our professional, caring staff is dedicated to providing comprehensive bereavement services to children, teenagers and adults.

Library & Educational Services

**Baptist College of Health Sciences**

Baptist Memorial College of Health Sciences is accredited by the Southern Association of Colleges and Schools Commission on Colleges to award the Bachelor of Science in nursing, the Bachelor of Health Sciences, and the Associate of Science in Pre-Health Studies. Educational programs are accredited by the appropriate professional organizations listed below. Additional information on the current accreditation status for diagnostic medical sonography, medical radiography, nuclear medicine technology, radiation therapy, and respiratory care is available on the respective program’s web pages.

Library
The Library at is an important part of the Center for Academic Excellence at the Baptist College of Health Sciences (Baptist College). Located on the first floor of the main campus of the college in Memphis, the Library provides services and resources to support the information and education needs of the faculty and students of the Baptist College. Whichever subject you are studying, we have the resources you need to research and complete assignments for your courses.

Quick Links: for access to a variety of online resources/databases to help with research assignments. Many of these contain full text articles in addition to references to articles.

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Health Statistics on the Web:
(A Selected List of Health Data Tools and Statistics)

Health Statistics Portals/Gateways
- [Partners in Information Access for the Public Health Workforce](http://phPartners.org)

CDC Data and Statistics:
- [BRFSS](https://www.cdc.gov/brfss) - Behavioral Risk Factor Surveillance System
- [CDC WONDER](https://wonder.cdc.gov) (Wide-ranging Online Data for Epidemiologic Research)
- National Center for Health Statistics (NCHS) [FastStats](https://www.cdc.gov/nchs/fastats)
- [NHANES](https://www.cdc.gov/nchs/nhanes) - National Health and Nutrition Examination Survey
- [WISQARS](https://www.cdc.gov/injury/wisqars) – Web-based Injury Statistics Query and Reporting System

National Data and Reference Centers
- [SAMHSA](https://www.samhsa.gov) - Substance Abuse & Mental Health Services Administration
- [Centers for Medicare and Medicaid Services](https://www.cms.gov) (CMS)

State and Local Data Sets and Statistics:
- [State Health Facts Online](https://www.kff.org/health-status-indicators) (Kaiser Family Foundation)
- [US Census On the Move](https://www.census.gov) – Snap Shots of State Population Data

CHSI – Community Health Status Indicators
- [America's Health Rankings](https://www.ahr.org) (United Health Foundation)
- [County Health Rankings and Roadmaps](https://www.countyhealthrankings.org) (Robert Wood Johnson Foundation)

International Statistics:
- [World Health Organization](https://www.who.int) – Statistical Information System (WHOSIS)
- [Global Health Facts.org](https://globalhealthfacts.org) – Kaiser Family Foundation
Baptist Memphis Education Center

The Baptist Memphis Education Center and Dr. H. Edward Garrett, Sr. Auditorium offers colleagues, physicians, and the community more than 20,000 square feet of conference and classroom space ideally suited to health care education and professional development as well as community gatherings like church and civic events and receptions.

Conveniently located on the Baptist Memphis campus, the facility allows Baptist to host large events while offering first-rate accommodations. An entire Health Education Wing is devoted to classroom space, and five dedicated conference rooms can hold around 25 people each.

Available for community events, continuing medical education seminars, lectures, and Baptist events, the Baptist Memphis Education Center is one of the foremost conference facilities in our region.

Dr. H. Edward Garrett, Sr. Auditorium

The facility’s centerpiece is the Garrett Auditorium, named in honor of Dr. H. Edward Garrett, Sr., who performed the world’s first successful coronary artery bypass graft in 1964. Dr. Garrett’s name represents true pioneering in the field of health care, as well as Baptist’s ongoing commitment to innovation.

The 250-seat auditorium is equipped with advanced audio/visual capabilities to enable all forms of presentation media, teaching approaches, and communication avenues.

Maury W. Bronstein Health Sciences Library (BMH Memphis)

The Bronstein Library at Baptist Memphis provides resources and services to support the information and education needs of physicians, nurses and professional staff within Baptist Memorial Health Care.

The Bronstein Library has:
- More than 40 medical and nursing journals
- More than 1,000 medical and nursing textbooks and monographs
- Access to several online databases, including PubMed and UpToDate
- Several computer terminals with Internet access

Books

The library’s book collection consists of reference books that may be used in the library and other medical or nursing books that may be checked out for up to two weeks. The online catalog contains information on all the books in the Baptist College of Health Sciences Library. The catalog (WebOPAC) is available on the Internet at [http://www.bchs.edu/content/library](http://www.bchs.edu/content/library).

Journals

The Bronstein Library subscribes to more than 60 medical and nursing journals, which are arranged on the shelves in alphabetical order. The Journal Holdings List is an alphabetical compilation of the journals in our library and is available upon request. In addition, the text of many of our journals can be accessed online.

Interlibrary Loans

Our interlibrary loan service provides articles from journals not available in the Bronstein Library collection. To obtain books or articles, please contact the library at 901-226-5569.

Online Databases
Medline is available on PubMed at [http://www.ncbi.nlm.nih.gov/PubMed](http://www.ncbi.nlm.nih.gov/PubMed) as a service with library staff available to run searches for you. Requests may be sent by phone, fax, email, or in person. Individual or small group PubMed instructional sessions are available and should be scheduled ahead of time by calling 901-226-5569.

UpToDate is an evidence-based clinical decision support database where medical professionals can get trusted clinical answers – guidelines, patient handouts, drug information – at the point of care when you need it most.

**Ann L. and Joseph H. Powell Library (BMH-Memphis)**

The Ann L. and Joseph H. Powell Library is a unique Consumer Library dedicated to educating our patients, families, and the public on a variety of health-related topics. This library contains books, periodicals, DVDs, anatomical models, and other educational materials, most of which are available for check-out. Established in March 2005 at Baptist Memorial Hospital-Memphis through a generous gift by former BMHCC President Joseph Powell and his wife, the 2,000-square-foot consumer library also features a meeting room complete with video teleconferencing.

**Neurology**

**Neurodiagnostics Laboratory**

The Neurodiagnostics Laboratory at Baptist Memorial Hospital-Memphis is internationally recognized for providing high-quality neurophysiologic testing for patients. Technology available at Baptist Memphis allows for the diagnosis and treatment of central nervous system disorders, such as head and spinal cord injuries, epilepsy, strokes, tumors, aneurysms and multiple sclerosis.

**Neurodiagnostic Tests**

Registered electroneurodiagnostic technologists perform all neurodiagnostic tests.

- Electroencephalogram (EEG)
- Visual Evoked Potential (VEP)
- Somatosensory Evoked Potential (SSEP)
- Electromyogram and Nerve Conduction Study (EMG/NCS)
- Intraoperative Monitoring (IOM)
- Treating Strokes

Baptist Memphis has the technology and the expertise to diagnose and treat strokes of all kinds: ischemic, hemorrhagic, and transient ischemic attacks. We also offer a full continuum of care, including rehabilitation services and support groups, for stroke victims.

Baptist Memphis has a 10-bed neuro ICU and a 40-bed neuro floor. There is a 40-bed intermediate level ICU step-down floor. Patients may be admitted to the neuro ICU as a direct admission, emergency admission, transfer from another critical care area, or from any nursing unit/department.

We offer advanced neuro diagnostic technology, including:

- Advanced Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Perfusion (MR Perfusion)
- Advanced Computerized Tomography (CT) technology and Computerized Tomography Angiography (CTA)
- Computerized Tomography Perfusion (CT Perfusion)
- Advanced Positron Emission Tomography technology
- Advanced Neuro Interventional Radiology for minimally invasive procedures.

Baptist Memphis has a multidisciplinary team of five neurologists, five neurointerventionalists, and more than a dozen neurosurgeons. The neuro ICU has critical care intensivists who are available in the ICU 24 hours a day.

**Teleneurology**
Baptist is working to keep distance from being something that prevents quality medical care. With a stroke or other neurological disorders, having immediate feedback can greatly improve medical care. Teleneurology brings patients together with experts who may be miles away.

**Oncology**

**Baptist Cancer Center-Memphis**

**Leading-edge Cancer Care Closer to Home**

Baptist Memorial Health Care created the Baptist Cancer Center (BCC), a comprehensive cancer program so strong that people throughout the Mid-South will be aware of and reassured by the competence and excellence of the program. The BCC is committed to providing Mid-South physicians, cancer patients and their families with the assurance and confidence that excellent, compassionate, advanced care is nearby.

**Baptist Comprehensive Breast Center**

At Baptist Memorial Hospital for Women, we don't want any woman to experience breast cancer alone. That's why we developed the Baptist Comprehensive Breast Center, a place where women can come for medical expertise, support and answers to their questions. The Baptist Comprehensive Breast Center, created in January 2003, gives women access to local breast cancer experts, breast health services and resources under "one roof."

This Comprehensive Breast Center, the first of its kind in Memphis, allows Baptist experts to coordinate a patient's care from one central location, making it easier for patients to navigate the breast cancer process. Most patients are introduced to the Comprehensive Breast Center at the time of their diagnosis, through the Baptist Women's Health Center or at the recommendation of their physician, who is a member of the Comprehensive Breast Center network.

**Continuum of Services for Cancer Care**

The Baptist Cancer Center provides the complete continuum of care for cancer patients—from diagnosis and treatment to follow-up care. The BCC team takes an interdisciplinary approach to patient care—making sure every patient need is met, from emotional support to pain management.

Through the BCC, Baptist Memphis offers treatment, research, support services, community education, and the area's first genetic counseling and testing program for cancer. In addition, the hospital has the Mid-South's first adult myelosuppression unit, which provides specialized care for patients who have received chemotherapy that interferes with blood cell production or stops bone marrow activity.

**Baptist Memphis Accomplishments & Firsts**

Setting new standards for the detection and treatment of cancer in the Mid-South, Baptist has accomplished many firsts including:

- In 2011, BCC-Memphis became one of the first hospitals in the area to offer Cyberknife treatment.
- In 2007, BCC-Memphis became the first in the MidSouth to deliver Image Guidance Radiation Therapy (IGRT).
- In 2007, BCC-Memphis became the first in the MidSouth to use Real-time Position Management™ (RPM) system - for gating perfectly timed beam delivery with minimal margins.
- In 2007, BCC-Memphis became the first in the MidSouth to deliver linear accelerator based Stereotactic Radiosurgery/Stereotactic Radiotherapy (SRS/SRT) in the treatment of cancer.
- First freestanding radiation therapy center at the Radiation Oncology Center at BCC-Memphis.
- First to provide prostate brachytherapy.
- First in Memphis to perform prostate brachytherapy, a nonsurgical way to treat prostate cancer.
- First in Memphis to use intensity modulated radiation therapy, new radiation treatment for cancer care in adults.
- In 2002, the Baptist Cancer Center at Baptist Memphis began preparation to conduct the first allogeneic stem cell transplant program in the Mid-South—a procedure in which an unrelated donor's stem cells are transplanted into cancer patients to help them recover from high-dose chemotherapy.
- In December 2002, Baptist Memphis was the first in the Memphis area to provide a cancer navigator to help guide cancer patients and their families through the cancer process.
In November 2002, the Radiation Oncology Center at BCC-Memphis was the first in the Memphis area to provide intensity modulated radiation therapy (IMRT) for the treatment of certain cancers in adults.

The Baptist Women’s Health Center was among the first seven centers in the nation to have a full-field digital mammography machine.

Baptist offers the only mobile mammography units in Shelby County.

Baptist introduced the first retail-based mammography center in Memphis in 2000.

In 1994, Baptist established the first and only myelosuppression unit in Memphis—a specialized oncology unit for high-risk patients with compromised immune systems.

The first adult autologous stem cell transplant in Memphis was performed at Baptist Memorial Hospital in 1989.

Orthopedics

Baptist Memphis is proud to be the first hospital in the Memphis area to perform a total joint replacement using ceramic-on-ceramic prosthesis, which helps prevent the breakdown of bones, such as the hip bone, associated with the traditional metal material used in hip replacements. In addition to a full range of inpatient orthopedic services, Baptist Memphis also offers a wealth of outpatient services at its Outpatient Rehabilitation Clinic.

Orthopedic Inpatient Unit

Baptist Memphis’ inpatient unit comprises 40 private rooms. Our team of clinical and nonclinical staff helps patients get the care they need so they may progress to either a rehabilitation facility or return home.

Orthopedic Rehabilitation Clinic

Baptist Memorial Hospital-Memphis offers physical and occupational therapy services, speech and language pathology services and a number of individualized treatment programs for both pediatrics and adults at its Outpatient Rehabilitation Clinic. Among the advanced services offered at the clinic is serial casing, which restores some movement in patients with muscular dystrophy and other conditions. Baptist Memphis is the only hospital in the Memphis area that offers this service.

Outpatient

Plaza Diagnostics Pavilion

Baptist Memorial Hospital-Memphis offers extensive outpatient services for adults and pediatrics, ranging from basic diagnostic services and rehabilitation to advanced procedures, such as stem cell transplants.

Services

- Audiology
- Interventional radiology
- Endovascular laser therapy (ELVT)
- Uterine fibroid embolization (UFE)
- Laboratory (draw station only)
- Neurosciences
- EEG
- EKG
- EMG
- Non-invasive cardiology
- Pulmonary physiology
- Radiology
- CT
- Coronary calcium scoring (HeartScore)
- Diagnostic radiology
- MRI
- Nuclear medicine
- Nuclear cardiology
• Position emission tomography (PET)
• Ultrasound

Sleep Disorders Center

Originally opened in the fall of 1977, the Baptist Collierville Sleep Disorders Center has evaluated more than 32,000 patients since its inception. The Baptist Sleep Disorders Center at Baptist Memorial Hospital-Collierville is a facility providing clinical diagnostic services and treatments to patients who have symptoms or features that suggest the presence of a sleep disorder. The center consists of eight individual sleep rooms with adjacent bathrooms. The center is staffed by highly trained and experienced polysomnography technicians. The center was one of the first to be accredited in the United States.

Pediatrics

Spence and Becky Wilson Baptist Children’s Hospital

The Spence and Becky Wilson Baptist Children's Hospital, part of Baptist Memorial Hospital for Women, is the home of our children's hospital services. The hospital features inpatient care offered in the Hardin Pediatric Center, PD's Perch outpatient center, specialty surgeries and a leading edge pediatric emergency room.

Hardin Pediatric Center

The Hardin Pediatric Center is designed for patients who require hospitalization. Special features include:

• Spacious, elegant, family-friendly rooms
• A DVD system in every room with movies available for all ages
• Pediatric physicians and nurses who communicate regularly with your pediatrician
• Pediatric hospitalists who provide 24/7/365 coverage

PD’s Perch

PD’s Perch is an outpatient testing and surgical preparation center. The Perch has a private waiting and play area with trained nurses who can prepare your child for any of the following procedures:

• Full service lab
• Foley catheters
• IV fluids
• Blood administration
• Antibiotic infusions
• Diagnostic X-rays
• CTs and MRI testing with and without anesthesia
• Ultrasounds
• EKG
• Fluoroscopy

Surgical Services

The Spence and Becky Wilson Children's Hospital offers many pediatric surgical services including:

• Ear, nose, and throat
• Orthopedic
• Plastic surgery
• Gynecological
• Ophthalmology
• General Surgery
• NICU surgeries
• Adolescent weight loss
• GI procedures
Pediatric ER

The hospital opened its 17,000 square-foot emergency room, which features 10 bays for patient care, and a 2,000 square-foot diagnostics area on January 28, 2015. The emergency department is staffed 24/7 with pediatric emergency medicine physicians, pediatric hospitalists and an array of other pediatric specialists, including the Baptist system’s first pediatric general surgeon and a pediatric anesthesiologist.

The Pediatric Emergency Department offers:

- Providers who have advanced training in emergency medicine for children
- Around-the-clock access to the staff and facilities at the Children’s Hospital including pediatric physician specialists, operating rooms, on-site MRI and CT
- On-site child life specialists to help children cope with their visit
- A child and family-friendly facility with child-sized equipment
- Sedation and anesthesia as needed to help children stay comfortable during potentially stressful procedures

Rehabilitation

Baptist Rehabilitation-Germantown

Baptist Rehab-Germantown began serving the Mid-South community in 1964. Our goal is to help children and adults disabled by injury or illness to achieve a renewed sense of independence and dignity. For these patients, independence does not come easily; it comes only through hard work, determination, therapies and a team effort.

Our expert team members are highly trained in their respective clinical areas and work as an interdisciplinary team to determine realistic goals and create a specialized program to meet the needs of each patient. Providing each patient with the best possible care and service is our No. 1 goal.

CARF Accreditation

In 2010, the Commission on Accreditation of Rehabilitation Facilities (CARF) accredited nine Baptist Rehabilitation Germantown Programs for the maximum of three years. CARF offers the highest accreditation a rehabilitation hospital can achieve.

- Rehabilitation Programs
- Stroke Program
- Brain Injury Program
- Spinal Cord Injury Program
- Amputation Program
- Inpatient Services
- Outpatient Services
- Pediatric Rehabilitation
- Next Step Day Treatment Program
- Radiology/Diagnostics
- Inpatient Rehabilitation

Inpatient rehabilitation therapies at Baptist Memphis serve the hospital’s acute care patients on a daily basis. Through a multidisciplinary approach, the inpatient rehab team strives to provide the best treatment for all patients to improve their functional status.

Other Specialty Services

- Personalized treatment plans
- Wound care
- Individualized splint fabrication
- Videofluoroscopy evaluations, an advanced way for physicians to analyze the spine and extremities
Amputation Program

The amputation program at Baptist Memorial Rehabilitation is offered by a comprehensive, multidisciplinary team of professionals with specialty training, experience and credentials for management of amputation and related conditions. The amputee injury team strives to provide effective and evidence-based care and outcomes related to the specific needs of the amputee population. Baptist provides a continuum of acute care, post-acute care, home care and outpatient services.

Traumatic and Non-traumatic Brain Injury Rehabilitation

Physical, occupational and speech therapists coordinate to provide targeted services addressing the varying needs of the brain injury population. Services range from physical dysfunction to cognitive and behavioral issues to prevocational needs. Our therapists have specialized skills and training designed to help them recognize the special needs of brain-injured individuals and provide consistent and structured rehabilitation. Our goal is for patients to achieve maximum independence. Consultative resources are available for psychological, vocational and driving assessment and services.

Stroke and Neurologic Rehabilitation

Our highly trained and experienced team of physical and occupational therapists and speech-language pathologists provides a multidisciplinary approach to outpatient neurologic rehabilitation services, emphasizing functional activities, as well as use and recovery of affected areas. In fact, many of our physical and occupational therapy staff have advanced certification in neurodevelopment techniques, which focus on functional recovery and normalized movement patterns. Understanding the special issues and lifestyle changes associated with disability, our therapists provide clinical and support services in a coordinated, caring and friendly manner. Patient and family education and participation, as well as linking patients and families to important community resources, is a vital part of our program.

Program components include:

- Functional mobility training
- Activities of daily living training
- Functional tone management training program for upper extremity recovery
- VitalStim therapy for dysphasia (swallowing disorders)
- Modified barium swallow studies
- Language and communication therapy
- Memory and cognitive retraining

Other Specialty Services

Occupational Therapy

The purpose of occupational therapy is to assist a person in restoring function lost because of disease process or injury. Occupational therapy uses functional activities help patients relearn activities of daily living skills, including:

- Self-feeding
- Dressing
- Grooming
- Using the restroom
- Meal preparation
- Household chores
- Work
- Leisure

Services

- Arm and hand exercises
- Fine motor coordination
- Sensory education
- Functional activities of daily living training
- Joint protection
- Energy conservation
- Work modification
- Visual perceptual re-education
- Hand therapy
- Customized splinting services

Physical Therapy

The purpose of physical therapy is to restore a person’s level of function by applying scientific principles to prevent, identify, alleviate or compensate for dysfunctions or injuries.

Specialized Treatments
Therapeutic strengthening exercises
Gait training
Muscle re-education
Balance/vestibular rehabilitation
Fall prevention
Joint and soft tissue mobilization
Range of motion

Coordination activities
Endurance training
Flexibility training
Sports related injuries
Orthopedic rehabilitation
Spinal and soft tissue mobilization

Speech-Language Pathology
Speech-language pathology specializes in providing comprehensive evaluation and treatment for speech, language, voice, cognitive and swallowing disorders that result from a variety of conditions, including:

- Strokes
- Head and neck cancer
- Vocal cord disorders
- Degenerative disorders
- Parkinson’s disease
- Dementia
- Dysfluency
- Stuttering
- Laryngectomy
- Nerve damage to muscles associated with speech or swallowing

Baptist Memory Care Center Services

The first of its kind in Memphis, our Memory Care Center is designed to connect individuals who may be suffering from Alzheimer’s, dementia and other memory related issues, and their caregivers with free screenings and other community resources. At the Baptist Memory Care Center our licensed clinical social worker provides free memory screenings by appointment and no referral is needed. We share results of a memory screening with caregivers and primary care physicians, as appropriate, to keep their whole care team informed and up to date.

Support Services

Our Memory Care Center staff provides support for our guests and their caregivers as they go through emotional and everyday life changes. Our support services include caregiving classes, community outreach services, support groups, and advanced care planning in addition to other services. Our team will assist in identifying available resources such as home care, respite care, day care, driving safety, specialty physician’s services, educational literature, community events, spiritual and emotional guidance and direction, acute care needs, and long-term care facilities.

Surgery

Ambulatory Centre / Surgery Services

Located within the Baptist Heart Institute on the Baptist Memphis campus, the Baptist Ambulatory Centre is the entry point for all elective inpatient and one-day surgeries, heart catheterizations and gastrointestinal procedures, and pre-surgery labs.

The center offers a full range of services, including:

Bronchoscopy
Electrophysiology studies (EPS)
Gastrointestinal lab procedures
Heart biopsies
Heart catheterizations

Invasive radiology procedures (myelograms, biopsies)
Lithotripsy
Preadmission labs/tests
Tilt Table Test (TTT)
Transesophageal echocardiogram (TEE)

da Vinci Surgical System

Baptist Memorial Hospital-Memphis acquired a da Vinci. No, the hospital has not purchased a painting. Rather, in the summer of 2003, Baptist Memphis became the first hospital in the Mid-South to own a new robotic surgery device called the da Vinci®.
The da Vinci Surgical System is powered by leading-edge robotic technology. It allows surgeons to perform major surgeries by making only small incisions. With the device, surgeons make four small incisions, inserting the robotic arms into the incisions to perform surgeries. The magnified, 3-D view the surgeon experiences enables him or her to perform precise surgery in complex procedures through small surgical incisions.

da Vinci Surgery at Baptist Memphis

At Baptist Memphis, the da Vinci can be used for prostate, open-heart, gynecologic, urologic and other surgical procedures. The system is the first totally "intuitive" laparoscopic surgical robot in existence.

To give perspective on the capabilities of the da Vinci, the camera's magnification of the surgical area is such that a suture, which is about the size of a piece of thread, appears the size of a rope. The camera allows surgeons to see more than they could if they were to do more invasive surgery.

Using the da Vinci Surgical System, the surgeon operates while seated comfortably at a console viewing a 3-D image of the surgical field. The surgeon's fingers grasp the master controls below the display with hands and wrists naturally positioned relative to his or her eyes. The robot technology seamlessly translates the surgeon's hand, wrist and finger movements into precise, real-time movements of our surgical instruments inside the patient.

Baptist Memorial surgeons have been specially trained to use the da Vinci technology, and have met all the clinical and experience criteria to perform a robotic prostatectomy.

Patient Benefits

Because surgeons make only small incisions, patients benefit in a number of ways, including:

- Reduced pain and discomfort after surgery
- Reduced blood loss
- Reduced surgical incisions
- Faster recovery and return to normal daily activities
- Reduced cost
- Reduced hospital stay

Women’s Health

Labor and Delivery

Baptist Memorial Hospital for Women has a 24-hour maternity ambulance entrance, 23 labor and delivery suites, 48 mother/baby rooms with a well-baby nursery. We designed the Labor and Delivery unit to be both high-tech and high-touch. These beautiful rooms are designed for comfort and convenience, offering TV/VCRs, CD players and showers. Each room has oversized couches so family members can stay with their loved ones in comfort.

Assessment

The Obstetrical Assessment area is where women are evaluated when brought to Baptist Memorial Hospital for Women in labor or with pregnancy-related complications. Nine semiprivate beds in this area allow patients privacy and comfort while physicians and nurses are tending to their needs.
Women's Health Center

The Baptist Women's Health Center is a full-service mammography and osteoporosis testing center dedicated to women’s health. Everything from screening mammograms to diagnostic mammograms are offered, as well as lymphedema treatment, education on breast health, and a breast cancer support group.

The center was among the first seven facilities in the nation to have a full-field digital mammography machine, and continues to lead the way in innovative care by offering:

- The region's first Breast Risk Management Center, including genetics counseling, for patients who may be at high risk for developing breast cancer.
- The only MRI-guided breast biopsies.
- The only mobile mammography units in Shelby County (including digital mammography).
- Second Look®, a computer-aided detection system that assists radiologists in early breast cancer detection without lengthening a patient's exam or office visit.
- Radiologists dedicated to mammography and breast imaging.
- Same-day results and consultation with doctors for diagnostic mammograms.
- Breast health specialists specializing in breast health who coordinate any necessary care and provide support to the patient.

All of this has contributed to the Women's Health Center being nationally recognized as an ACR-accredited center of excellence in mammograms, stereo biopsy, and breast ultrasound — the only center of excellence in East Memphis. Plus, our high-quality of care has been recognized by the National Accreditation Program for Breast Centers and the American College of Radiology, placing our facility in the top five percent of the nation for clinical excellence.

Osteoporosis

About 28 million Americans have osteoporosis. Nearly 80 percent of these are women. About one out of two women 50 and older will have an osteoporosis-related fracture in their lifetime. The most typical sites of fractures related to osteoporosis are the hip, spine, wrist and ribs, although the disease can affect any bone in the body.

The only accurate way to diagnose osteoporosis is through a screening test called bone densitometry, which can also predict your chances of having a bone fracture in the future, determine your rate of bone loss, and monitor the effects of treatment.

Baptist OneCare (EMR)

The Baptist OneCare system has created a single patient record that both caregivers and patients are able to access. The Electronic Medical Record (EMR) system aims to maximize efficiency by reducing the need for duplicate tests and for our patients to provide the same information to multiple caregivers.

Patients may access their EMR records through MyChart, a free app accessible via Smartphone or computer that allows patients to schedule appointments, refill prescriptions, direct message their care providers with the option of including photos, access lab results and much more.

Baptist OneCare is an Epic product that was chosen after conducting detailed research and involving colleagues in numerous demonstrations. Baptist sought feedback from healthcare providers from within the system before making a decision.

With well over 300 customers, Epic serves more than 42% of the U.S. population and two percent of the world's population. Epic is known for making software geared toward use by mid-size and large hospital systems. KLAS’ 2012 Top 20 Best in KLAS Report rated Epic as the No. 1 Overall Software Suite based on 25 separate performance measures. KLAS is an independent company that measures vendor performance to help hospitals make informed decisions. The same KLAS survey rated Epic as the best in ambulatory care and acute care electronic medical records, among others.
Other Services

Hospital Services

Audiology
Blood Bank/Donor Center
Blood collection and processing
Cardiac brachytherapy
Cardiac Intensive Care
Coronary calcium scoring (HeartScore)
CT scan
Echo services
Electrocardiography
Electromyography
General surgical services
Heart transplant services
Heart catheterization
High dose rate brachytherapy
Intensity modulated radiation therapy (IMRT)
Intravascular brachytherapy
Laser surgery
Lithotripsy
Low dose rate brachytherapy
Medical and surgical acute care
Medical and surgical intensive care
MRI
Neurological intensive care
Neurological services
Non-invasive vascular studies
Nuclear medicine
Oncology services
One-day surgery
Open heart surgery

Plaza Diagnostic Pavilion, outpatient diagnostic testing for adults
Outpatient rehabilitation services (physical, occupational and speech-language therapies)
PET scanning
Prostate implant brachytherapy
Pulmonary lab services
Radiation therapy
Radiology services
Inpatient rehabilitation services for inpatients (physical, occupational, speech-language and recreational therapy)
Renal dialysis services
Respiratory therapy
Stem cell transplant unit (autologous and allogeneic transplants)
Ultrasound

Emergency Services

All emergency services available except trauma
Pediatric emergency department with 24-hour, in-house pediatrician coverage
Fast track area for non-emergency care

Miscellaneous Services

Cancer/Tumor Registry
Cardiac rehab
Heart Registry
Knee/hip replacement classes
Interpretation services for hearing impaired and non-English speaking patients
Physician referral service
Wellness program
Letter of Commitment

December 13, 2013

Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, Illinois 60654

To Whom It May Concern:

In the spirit of excellence in patient care, it is our pleasure to write this letter in support of our proposed Graduate Medical Education programs at Baptist Memorial Hospital – Memphis (BMH-M). The Accreditation Council for Graduate Medical Education (ACGME) has awarded this facility institutional accreditation which is evidence of our cooperative spirit and the dedication to quality that defines Baptist. We fully realize the ongoing administrative and fiduciary responsibilities associated with the current Radiology program based at BMH-M and are pleased to expand this level of commitment with the addition of a Family Medicine program. We welcome the opportunity to serve the people of our community by the training of new physicians who will help to fill the ongoing need for Family Physicians in our region. The purpose of this letter is to outline the commitment and support of Graduate Medical Education (GME) and the administration of Baptist Memorial Hospital – Memphis.

Commitment

Baptist Memorial Hospital – Memphis firmly believes that medical education improves the quality of medical care provided by physicians, nurses and other health professionals within our facilities and in the community. To this end, we are committed to providing the necessary educational, financial, and organizational resources for graduate medical education. This support includes the necessary human resources, supplies, space, technology, and communications to impart professionalism, ethics, and personal development for the high quality training of resident physicians. Once their training is complete, these doctors will help address the widespread need for well-trained physicians regionally and throughout the nation.

Financial Support

BMH-M understands that graduate medical education programs cannot be expected to be financially self-supporting. Thus, the Baptist facilities that sponsor GME programs make substantial financial and human resources commitments to our programs’ operation and evolving needs. This commitment is determined in a simple, straightforward manner. An expense budget for each facility is developed annually based on the number of resident FTEs projected for that facility. Reimbursement received from patient care and CMS is distributed based on this same FTE model. Each facility currently sponsoring GME programs is committed to this endeavor and fully intends to continue their support.

Graduate Medical Education Committee (GMEC)

Graduate Medical Education Committee is well established at Baptist Memorial Hospital – Memphis. This committee is comprised of residents, medical staff and administrative representatives from all Baptist facilities involved in Graduate Medical Education. Additional representatives from our affiliated institutions...
also serve on the Baptist GMEC. The GMEC reports to BMHC Medical Executive Committee (MEC). Ultimate oversight for GME is provided by the Baptist Board of Directors.

The BMHC GMEC meets every other month and is responsible for the oversight of graduate medical education at all Baptist facilities. This committee provides oversight for all annual program reviews, special reviews, and GME policy administration. The committee is led by the Designated Institutional Official (DIO)/ Chief Academic Officer (CAO) for Baptist Memorial Health Care who reports to the Chief Medical officer for Baptist Memorial Health Care. The DIO reports bimonthly to the Medical Executive Committee (MEC) to communicate issues of patient safety, quality, educational, and supervisory needs of the education programs. This information is communicated in turn to the Board of Directors as a part of the report of the MEC.

**Designated Institutional Official (DIO)**
Baptist Memorial Health Care has appointed the Chief Academic Officer to serve as the Designated Institutional Official (DIO). Each Program Director designated by the DIO, has the authority and responsibility for the oversight and administration of his or her training program and is responsible for assuring the compliance with ACGME requirements.

The DIO’s responsibilities include the following:

1. Provide oversight and guidance to Program Directors for all submissions to the Accreditation Council for Graduate Medical Education (ACGME)
2. Provide oversight and administration of the Sponsoring Institution’s ACGME-accredited programs and ensure compliance with the ACGME Institutional, Common, and Specialty/ Subspecialty-specific Program Requirements.
3. Review and approve this letter at least every five (5) years
4. Provide an annual written report on the current GME programs to the Baptist Board of Directors
5. Appoint qualified and attentive Program Directors for each residency program sponsored by Baptist Memorial Health Care
6. Work with the Program Directors to help maintain sound training programs for the residents and medical community
7. Provide guidance to the MEC for all GME related issues
8. Maintain the affiliate relationships with the University of Tennessee Health Science Center and Vanderbilt University Medical Center
9. Support the undergraduate and graduate medical curriculums in this community
10. Prepare an annual residency budget and manage its implementation
11. Provide an annual report to the governing body of Baptist Memorial Health Care

The Program Director’s responsibilities include the following:

1. Be independently responsible for the operation and oversight of the program
2. Prepare and submit all information required or requested by the ACGME
3. Administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas
4. Implement and ensure compliance with all institutional policies and procedures including those concerning duty hours, working environment, and moonlighting
5. Supervise the structure, curriculum, and operation of the residency to meet the needs of the residents and to maintain accreditation by the ACGME
6. Recruit and coordinate the selection of residents
7. Recruit faculty, coordinate their responsibilities, and maintain a system for development, evaluation, and feedback to achieve optimal faculty and resident performance
8. Recruit and evaluate members of the medical staff to serve as preceptors and supervisors
9. Evaluate the performance of residents and provide feedback on their performance
10. Maintain systems for obtaining and utilizing residents’ feedback, and provide them systems for professional and personal support

Continuing Medical Education
With the support of hospital resources, the Chief Academic Officer also provides oversight in cooperation with Baptist Clinical Education and Organizational Development (CEOD) to coordinate a comprehensive schedule of conferences throughout the year. These conferences meet the ongoing Continuing Physician Professional Development (CPPD) needs of residents and area physicians.

Other Affiliations
Because of this recognized long commitment to excellence in medical education, Baptist Memorial Hospital – Jonesboro serves as a Regional Medical Education Center with dual affiliations with Arkansas State University and the Vanderbilt University Medical Center. This letter is reviewed and updated at least every five (5) years. In this role, GME coordinates the policies, rotations, and communications for learners and encompasses undergraduate, graduate, post-graduate levels and fellows. This ensures the quality and safety of the educational programs provided by the various Baptist facilities and overseen by the governing authorities of Baptist Memorial Health Care.

Derrick Zeigler
President and CEO
Baptist Memorial Hospital - Memphis

Christian C. Patrick, MD, PhD
Chief Medical & Academic Officer
Baptist Memorial Hospital - Memphis

Cyndi Pittman
Chief Financial Officer
Baptist Memorial Hospital - Memphis

Anne Sullivan, MD
Chief Academic Officer and DIO
Baptist Memorial Health Care
Our History

Dr. Scott Morris, a family practice physician and ordained United Methodist minister, founded the Church Health in 1987 to provide quality, affordable healthcare for working, uninsured people and their families. Thanks to a broad base of financial support from the faith community, and the volunteer help of doctors, nurses, dentists and others, the Church Health Clinic has grown to become the largest faith-based healthcare organization of its type in the country. Currently, we care for more than 58,000 patients of record without relying on government funding. Fees are charged on a sliding scale based on income. The average visit costs about $25.

In 1986, after college, seminary, medical school and his ordination as a United Methodist minister, Dr. Morris moved to Memphis, one of the poorest major cities in America. Dr. Morris knew the need would certainly be there, and if the Center could work in Memphis, it could work anywhere.

That same year, Dr. Morris was appointed as an associate pastor at St. John's United Methodist Church (a position he still holds today) and he began to plan and to raise the initial funding for the Church Health. St. John's purchased the Center's first building, a dilapidated boarding house across the street from the church, and agreed to lease it to the Center for $1 per year. Central Church agreed to finance the renovation of the building and its conversion to a clinic. The Plough Foundation and Methodist Hospital each agreed to give funding to launch the Center. Dr. Morris and one nurse saw 12 patients on September 1, 1987, and since then the Church Health has grown to handle more than 42,000 patient visits at its clinic each year.

But healthcare is about more than just prescribing pills. We at the Church Health believe we have a responsibility to take care of the bodies God gave us, so we have been committed from our beginning to health education and prevention. Our wellness ministry now offers everything from personalized exercise plans and cooking classes to group exercise classes and activities for children and teens. Church Health Wellness is open to the entire community with fees charged on a sliding scale based on family size and income. More than 125,000 member visits are recorded annually.
Our Mission

The Church Health seeks to reclaim the Church’s biblical commitment to care for our bodies and our spirits.

Our Core Values

Our ministries provide healthcare for the working uninsured and promote healthy bodies and spirits for all.

**Trusted** - Those we serve depend on us to do what we say we will do, today and in the future. Our donors and volunteers trust us to be good stewards of their gifts.

**Compassionate** - There is a sweet spirit in this caring place. We are encouraging, supportive and welcoming.

**Committed** - We are not going away. We are faithful to our mission and, with the help of others, will sustain our ministries.

**Quality** - We provide innovative, whole person care using best practices and highest standards, which is good enough for our mothers.

Commitment to Provider Training

The Church Health wants to expand its commitment to educational programs and training. We are committed to serving as the foundation for educating young medical providers and providing physician role models. We will support a training model of continuous, comprehensive, convenient, accessible and coordinated patient care. Our staff is dedicated to education and the care of patients within the practice as it relates to the greater community and the community we serve.

**Family Medicine Residency Program**

Do you feel called to serve those in need because of your faith? Are you ready to cut your teeth in an innovative environment that cares for the whole person? Along with Baptist Memorial Healthcare System, the Church Health is working to create a family medicine residency program beginning July 2015.

This residency will participate in ERAS (Electronic Resident Application Service) and NRMP (National Resident Matching Program).
Our Leadership Team

G. Scott Morris, M.D., M.Div.
Founder and
Chief Executive Officer

Ann Langston
Senior Director
Strategic Relationships & Opportunities

Susan Nelson, M.D.
Medical Director

Jennie Robbins
Senior Director
Finance and Performance

Michaelia G. Sturdivant, R.N.
Senior Director
Reach Programs

Jenny Bartlett-Prescott
Senior Director
Integrated Health Programs
Church Health  
Statement on Commitment to Knowledge Enhancement  
And Educational Programming  
As of November 17, 2014

The *Church Health* is growing to serve more and to serve better. After almost three decades of delivering innovative health and wellness services, *The Center* is clarifying the organizational *Aims*, which will define its focus for the next phase of delivering innovative care to the community in Memphis.

A key organizational objective incorporated into the *Church Health’s* five-year plan is to enhance knowledge and educational programming through research, curriculum development and professional education. Specifically, *The Center* seeks to provide formal educational opportunities for healthcare and other professionals, with a first priority being the development of its medical residency program.
Resolution of the Board of Directors
of the
Church Health Center of Memphis, Inc.
In Support of Educational Programming and Training

Whereas, the Church Health Center of Memphis, Inc. (“Center”) was organized exclusively for religious, charitable and educational purposes;

Whereas, the Center has been and continues to provide intern and scholar opportunities for people who want to gain experience and education working in the Center’s ministries;

Whereas, the Center wants to expand its commitment to educational programs and training;

BE IT RESOLVED, the Center is committed to being a family medicine residency site of the highest quality, serving as the foundation for educating residents and providing family medicine physician role models. The Center will support a residency site that provides continuous, comprehensive, convenient, accessible and coordinated patient care. The Center will have a staff dedicated to education of family practice residents and the care of patients within the practice as it relates to the greater community and the community served by the residency program.

Adopted this 27th day of January, 2014.

[Signature]
Corporate Secretary
THE MODEL FOR HEALTHY LIVING
A TOOL FOR EXPLORING THE INTERCONNECTEDNESS OF LIFE

- Faith — Building a relationship with God, your neighbors and yourself.
- Movement — Discovering ways to enjoy physical activity.
- Medical — Partnering with your health care provider to manage your medical care.
- Work — Appreciating your skills, talents, and gifts.
- Emotional — Managing stress and understanding your feelings to better care for yourself.
- Food — Making smart food choices and developing healthy eating habits.
- Community — Giving and receiving support through relationships.
Mission, Vision, and Value Statements

**Baptist Memorial Health Care**  
Mission, Vision, & Values

**MISSION**
In keeping with the three-fold ministry of Christ – Healing, Preaching and Teaching – BMHCC is committed to providing quality health care.

**VISION**
We will be the provider of choice by transforming the delivery of health care through partnering with patients, families, physicians, care providers, employers and payers; and by offering safe, integrated, patient focused, high quality, innovative cost-effective care.

**VALUES**
Compassionate Care and Service; Teamwork and Trust; Innovation and Excellence; Respect for the Individual and the Value of Diversity.

**Graduate Medical Education Mission Statement**
Graduate Medical Education is committed to providing oversight, guidance, and assistance to the facilities, programs, residents, and student which we serve in their pursuits of excellence in quality education and patient care.

**Family Medicine Program Mission Statement**
Reflecting the synergistic missions of our parent partners:
- **BMHCC** is committed to providing quality health care in keeping with the three-fold ministry of Christ: Healing, Preaching, and Teaching.
- **The Church Health** seeks to reclaim the Church’s biblical commitment to care for our bodies and our spirits.

The BMHCC/CH Family Medicine Residency’s mission is to provide high quality Family Medicine resident education in an environment of high quality Family Medicine patient care across clinical continuums, which will emphasize both the holistic approach to comprehensive individual health and the coordination and collaboration required across disciplines to improve outcomes for diverse populations. Our graduating Family Physicians will be prepared to practice the art of Family Medicine with joy and dedication, while mastering the science and technology of the evolving health care system, in order to become leaders in advanced primary care practices for our community and nation.
General Program Description

Baptist Memorial Health Care

Family Medicine Residency Program

Our Program

Our Family Medicine residency program is co-sponsored by Baptist Memorial Hospital – Memphis and the Church Health in Memphis, Tennessee. We are an Urban/Suburban program that is dedicated to creating outstanding family physicians with a commitment to providing care to patients and families from all walks of life. We emphasize our responsibility to God and our community to assist the less fortunate among us by offering each individual innovative care following best practice models to achieve and maintain the highest standards. To that end, our program curriculum includes requirements, as well as additional opportunities, for volunteer and leadership activities.

Our Family Medicine Practice (FMP)

The Family Medicine Practice (FMP) / Continuity Clinic for our program is currently located at 1115 Union Avenue, Memphis, Tennessee 38104. Our FMP contains nine (9) patient exam rooms, a waiting room with separate child play area, lab with technician, precepting room, resident/faculty work area, and conference room. This facility also utilizes nurses, nurse practitioners, and office staff.

This facility is housed in the Wellness building of the Church Health; an 80,000 square foot building located in the heart of the Memphis Medical Center. Church Health Wellness provides a safe, climate controlled facility for the community. Memberships are available on a sliding scale based on family size and income. Programs offered at the Wellness Center include:

- Exercise and Nutrition Planning
- Expansive Exercise Equipment Area
- Racquetball and Basketball Courts
- Walking Track
- Therapeutic Pool Classes
- Group Exercise Classes
- Aerobics
- Strengthening
- Yoga
- Pilates Mat and Reformer sessions
- Health Education
- Diabetes Education
- Smoking Cessation
- Nutrition Education Classes
- Healthier Cooking Demonstrations
Our Sponsors

Information about Baptist Memorial Health Care and the Church Health is included in the Introduction to this handbook.

Our Program Director

Anne L. S. Sullivan, M.D., FAAFP is a graduate of the University of Iowa (undergrad and MD). She completed her residency in Family Practice at Harbor-UCLA Medical Center and San Pedro Peninsula Hospital and has a CAQ in Adolescent Medicine. She began teaching in Family Medicine in 1997 and currently serves as the Chief Academic Officer for Baptist Memorial Health Care, Adjunct Clinical Associate Professor for the University of Tennessee Health Science Center, and as Medical Director of Quality Programs for Baptist Medical Group in addition to her responsibilities as Program Director for our program. She practices Family Medicine with Family Physicians’ Group in Memphis, Tennessee.

Our Future

The Family Medicine residency program at BMHCC/ CH was awarded accreditation by the Accreditation Council for Graduate Medical Education (ACGME) effective July 1, 2015. We matriculated our first academic class on July 1, 2016 and will continue to accept four residents per year for a maximum three-year program size of twelve.

The FMP will relocate to a new building in March of 2017. This “new” facility will be housed on the ground floor of the 1.5M square foot Sears Crosstown building which is the result of the $200M Crosstown Renovation project. In addition to our FMP, the Crosstown building will also contain 260 apartments, a charter school, and will include such tenants as St. Jude Children’s Research Hospital, Crosstown Arts, Gestalt Community Schools, Memphis Teacher Residency program, Methodist Le Bonheur Healthcare, and Rhodes College.

The new location of Church Health will expand the footprint of Church Health from 120,000 square feet in thirteen buildings to 150,000 square feet in one building. What will this mean for our patients?

<table>
<thead>
<tr>
<th>Room Type</th>
<th>2016</th>
<th>2017</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Rooms</td>
<td>34</td>
<td>62</td>
<td>77%</td>
</tr>
<tr>
<td>Dental operatories</td>
<td>10</td>
<td>24</td>
<td>140%</td>
</tr>
<tr>
<td>Eye treatment rooms</td>
<td>4</td>
<td>15</td>
<td>300%</td>
</tr>
<tr>
<td>Counseling rooms</td>
<td>4</td>
<td>12</td>
<td>200%</td>
</tr>
<tr>
<td>Group exercise rooms</td>
<td>1</td>
<td>2</td>
<td>100%</td>
</tr>
</tbody>
</table>

1. **Check-In/Walk-In Clinic:** A convenient drop-off for our patients means quicker access to our urgent-care clinics and rehabilitation services.

2. **Medical Clinic:** A 77 percent growth of our medical clinic means we can serve more people and serve them better.

3. **Child Life Education and Movement:** We partner with you and your children to get healthier through nutrition, physical activity, self-image, body image, safety education and violence prevention.

4. **Teaching Kitchen:** Food can be a healing medicine if you know how to prepare it. Medical professionals and community members will learn to prepare healthy, nutritious foods that improve health.

5. **Chapel:** Church Health is here not only to provide quality, affordable healthcare, but also to serve those who feel a brokenness in spirit.
6. **Broadcast Booth:** Church Health will broadcast an array of faith and health programs and work with other partners to showcase Crosstown Concourse and what’s great about Memphis.

7. **Rehabilitation Services:** With a 50 percent increase in space for physical therapy, we will be able to provide better service to our patients recovering from illness or injury.

8. **Church Health YMCA:** Through our partnership with the YMCA, people will get the best of what each organization has to offer. Membership will be open to everyone.

9. **Dental Clinic:** Increasing our dental capacity by 140 percent will reduce wait times and allow us to care for more people.

10. **Eye Clinic:** Increasing our capacity by 300 percent, Church Health has partnered with Southern College of Optometry to provide better service to our patients.

11. **Behavioral Health:** Our emotional health is an important part of our overall health. Our capacity will grow by 200 percent.
2016 - 2017 Residents’ Benefits Package
Baptist Memorial Hospital / Memphis, Tennessee

Health Insurance (Aetna) – Baptist offers a choice of two health insurance plans:

- Aetna 80/20 Plan – Calendar year deductible ($600.00 individual), copays ($25.00-$50.00), coinsurance payments (80% coverage after deductible is met).
- Aetna Whole Health Consumer-Driven Health Plan (CDHP) – High calendar year deductible ($1500.00 individual / $3000.00 family), lowest monthly rate, 90-100% coverage after deductible is met, tax-favored Healthcare Savings Account for out-of-pocket expenses.

NOTES:
- All of these plans utilize the CVS / Caremark Prescription Drug plan
- Pre-existing conditions are covered
- Out-of-Network Providers/Facilities are not covered

Dental Insurance (Humana) – Baptist offers a choice of two dental insurance plans:

- Dental High ($2000.00 maximum annual coverage with a higher monthly rate)
- Dental Low ($1500.00 maximum annual coverage with a lower monthly rate)
- 100% coverage (usual and customary) for preventive care
- 80% coverage (usual and customary) for basic care and major restoration
- 50% coverage for orthodontic treatments up to age 19 with a $1000.00 maximum lifetime benefit

Vision Insurance (DavisVision) – Coverage is available for the employee, employee’s spouse, and dependent children up to age 26. Highlights include:

- $10.00 co-pay for annual exam
- $25.00 co-pay for annual lenses or frames
- Other co-pays for additional services

Life Insurance (Standard Insurance) - Coverage is provided for all full-time employees after 90 days of employment for 1 ½ of his/her annual salary up to $50,000.00 at no cost. Additional coverage is available for the employee, spouse, and dependent children up to age 26.

Disability (Liberty Mutual) – Long-term disability coverage is provided at no cost to the resident / fellow after 90 days of employment.

Additional Benefits – Other benefits that are offered to Baptist employees include:

- Wellness Program – Baptist Memorial Hospital – Memphis provides a well-maintained gym that is accessible to employees (and their dependents / restrictions apply) 24/7/365 at no cost.
- Additional information about benefits is available through Human Resources and during New Employee Orientation.
- Baptist provides an additional stipend to each resident’s base salary equal to the cost of the Aetna Whole Health 80/20 Plan, Dental High, and Vision Insurance for the resident and his/her immediate dependents (spouse and children) if applicable
- Accident Indemnity Plan provided by Aflac
- Cancer Protection Plan provided by Aflac
- Flexible Spending Accounts
  - Healthcare Spending Account (not available to employees with a Healthcare Savings Account)
  - Dependent Care Spending Account
- Healthcare Savings Account available for participants in the CDHP health insurance plan
- Veterinary Pet Insurance available at competitive rates
- Purchasing Power (payroll deduction option for personal purchases through this program)
- HealthNet Federal Credit Union
- CONCERN Employee-Assistance Program
- Annual PTO allotment of up to 184 hrs (23 days) and Annual Sick Time allotment of 120 hrs (15 days) / both are non-cumulative
- Employee Discounts – All Baptist employees may receive discounts with various vendors. Check the Baptist Intranet for info.

ALL BENEFITS ARE SUBJECT TO CHANGE
Graduate Medical Education

AY16/17 Resident Stipends

Effective Date: July 1, 2016

<table>
<thead>
<tr>
<th></th>
<th>July 2016 - June 2017 Basic Stipends</th>
<th>AAMC 25% South Region in AY15</th>
<th>AAMC Median South Region in AY15</th>
<th>AAMC 75th Percentile in AY15</th>
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<tr>
<td>PGY 1</td>
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<td>$ 50,988.00</td>
<td>$ 52,525.00</td>
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Resident Stipends With Institution-Paid Health/Dental/Vision Insurance

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Spouse</th>
<th>Children</th>
<th>Family</th>
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<td>PGY 1</td>
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<td>$ 52,537.12</td>
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<tr>
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<td>$ 54,340.50</td>
<td>$ 54,337.12</td>
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<tr>
<td>PGY 3</td>
<td>$ 54,593.16</td>
<td>$ 56,090.50</td>
<td>$ 56,087.12</td>
<td>$ 57,081.62</td>
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</tbody>
</table>
Objective(s):

To contribute to more effective patient care through recognition and support of patient rights.

To increase satisfaction of patients, physicians, and healthcare providers through recognition and support of patient rights.

To recognize and support special needs of children and adult patients in skilled nursing, mental health and behavioral health facilities.

To provide quality patient care without regard to patient age, sex, sexual orientation, gender identity or expression, race, color, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status or any other class, status or condition protected by law.

Policy:

I. Commitment

Baptist recognizes and supports the “Patient’s Bill of Rights”, “Children’s Bill of Rights”, “Skilled Nursing Facility Patient Rights” and “Behavioral Health Bill of Rights”.

Staff observes and contributes to these rights for effective patient care and greater satisfaction for patients, their physicians, and the healthcare providers.

Recognizing that some patients, especially children, may be unable to voice their needs or assert their rights, family members, parents, and/or guardians are recognized as extensions of patients.

II. Notification

At time of entry, all inpatients and outpatients are notified and provided a copy of the Patient Bill of Rights.

III. Medicare Patients

In addition to the Bill of Rights, Medicare patients are provided a copy of the Important Message from Medicare which further explains their rights as a Medicare patient.
Patient Bill of Rights

A. You or your legally designated representative has the right to be informed about your illness, possible treatment options, and likely outcome(s), including unanticipated outcomes, and to participate and make informed decisions regarding your care. You have the right to know the names and roles of healthcare providers treating you.

B. You have the right to designate all family/support persons and visitors, regardless of the type of relationship.

C. You have the right to have an advance directive, such as a living will or health care proxy. These documents express your choices about your future care or name someone to decide if you cannot speak for yourself. If you have a written advance directive, you should provide a copy to the hospital, your family, and your doctor.

D. You have the right to privacy and personal dignity. The hospital, you, your doctor, and others caring for you will protect your privacy as much as possible.

E. You have the right to receive care in a safe setting, free from abuse, harassment, financial and other exploitation and you have the right to access protective and advocacy services.

F. You or your legally designated representatives have the right to review your medical records and to have the information explained except when restricted by law.

G. You have the right to expect that treatment records are confidential unless you have given permission to release information; or reporting is required or permitted by law. You have the right to access your medical record, request amendment(s), and receive an accounting of disclosures regarding your health information.

H. You have the right to be free from restraints or seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff.

I. You have the right to expect the hospital will give you necessary health services to the best of its ability. Treatment, referral, or transfer may be recommended or requested. You will be informed of the risks, benefits, and alternatives. You will not be transferred until the other institution agrees to accept you.

J. You have the right to considerate, dignified and respectful patient care, treatment and services that includes consideration of your psychosocial, religious, spiritual, personal values, beliefs and cultural variables that influence the perceptions of illness.

K. You have the right to consent to or refuse a treatment, as permitted by law, throughout your hospital stay. If you refuse a recommended treatment, you will receive other needed and available care.

L. You have the right to access interpretation if necessary for effective communication.
M. When you enter the hospital, you sign a general consent to treatment. In some cases, such as surgery or experimental treatment, you may be asked to confirm in writing that you understand what is planned and agree to it. This process protects your right to consent to or refuse a treatment. Your doctor will explain the medical consequences of refusing recommended treatment. It also protects your right to decide if you want to participate in a research study.

N. You have the right to be told of realistic care alternatives when hospital care is no longer appropriate.

O. You have the right to know if this hospital has relationships with outside parties that may influence your treatment and care. These relationships may be with educational institutions, other health care providers, or insurers.

P. You have the right to comfort and dignity in the face of death, the treatment of primary and secondary symptoms as desired and effective pain management. Psychosocial and spiritual concerns of the patient and patient’s family during this time will be acknowledged as well as the need for expression by the patient and the family.

Q. You have the right to an assessment and management of pain, including initial assessment and regular assessment of pain, and to expect education of all relevant providers in pain assessment and management. You will receive education, along with your family/support person, when appropriate, regarding managing pain as well as the potential limitation and side effects of pain treatments, and after taking into account personal, cultural, spiritual, and, or ethnic beliefs, communicating to you and your family/support person that pain management is an important part of care.

R. You have the right to expect a family member or representative and a physician will be notified promptly of your admission to the hospital.

S. You have the right to know about hospital rules that affect you and your treatment and about charges and payment methods. You have the right to know about hospital resources, such as representatives of ethics committee that can help you resolve problems.

T. You have the right to express a grievance concerning your care and receive a response without your care being compromised by calling the hospital’s patient representative or 1-877-BMH-TIPS. You have the right to access and internal grievance process and also to appeal to an external agency. State agencies: Arkansas Department of Health, 1-501-661-2000, Mississippi Department of Health, 1-800-277-2308 or 1-601-362-2194, Tennessee Department of Health at 1-800-852-2187, or the Joint Commission, 1-800-994-6610 or email complaint@jointcommission.org.
Children’s Bill of Rights

A. Children have the right to be respected as unique individuals and be members of the family regardless of needs complicated by hospitalization. Children and/or their parents have the right to designate all family/support persons and visitors, regardless of the type of relationship.

B. Children have the right to establish/maintain parent-child relationships including 24-hour presence/rooming in with their parents unless such presence interferes with safety and recovery.

C. Children have the right to communicate and/or visit with siblings unless visitation interferes with safety or recovery.

D. Children have the right to receive age and developmentally appropriate care that includes space, equipment and programs for the wide range of play, education and socialization essential to growth and development.

E. Children have the right to already established supportive home patterns of interactions and routines.

F. Children have the right in the absence of their parents to have consistent emotional support and nurturing care.

G. Children have the right to an environment, which is aware of the individual’s ethnic, cultural, developmental and academic needs.

H. Children have the right to receive care from professionals skilled in assessing emotional, physical, developmental and academic needs.

I. Children’s families have the right to assistance concerning finances, housing, and coping needs during hospitalization.

J. Children have the right to have their physician and a family member notified of the hospital admission.

K. Children have the right to a safe setting, be free of abuse and harassment, and access to protective services.

L. Children have the right to be free from seclusion and restraints of any form that are not medically necessary and do not improve the well-being of the child.

M. Children have the right to an assessment and management of pain, including initial assessment and regular assessment of pain, and to expect education of all relevant providers in pain assessment and management. Children should receive education, along with parents/representatives, when appropriate regarding their parents/representatives role in managing pain as well as the potential limitation and side effects of pain treatments, and after taking into account personal, cultural, spiritual, and/or ethnic beliefs, communicating to the child and parents/representatives that pain management is an important part of care.

Exceptions

A. If a parent or guardian is believed by the physician to seriously endanger the child’s health or safety, Baptist will pursue avenues necessary for a resolution that protects the child.
Baptist supports the “Patient Bill of Rights” for adults and children to the extent that they do not conflict with other Baptist policies, regulatory or legal constraints, or steps necessary from time to time to ensure Baptist financial viability.

**Patient and/or Family/Support Persons and Visitor Responsibilities**

A. You are responsible for providing information about your health, including past illnesses, hospital stays, and the use of medicine(s) to include over-the-counter medications and herbal remedies.

B. You are responsible for asking questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment, you are responsible for informing your doctor or the health care professional.

C. You and your family/support persons and visitors are responsible for being considerate of the needs of the patients, staff, and the hospital.

D. You are responsible for providing information for insurance and for working with Baptist, when needed, to arrange payment.

E. You are responsible for recognizing the effect of lifestyles on your personal health. Your health depends not just on your hospital care but on the decisions you make in your daily life.

F. Visitation may be restricted or limited for the following reasons by the health care professional:

1. Any court order limiting or restricting contact;
2. Behavior presenting a direct risk or threat to the patient, hospital staff, or others in the immediate environment;
3. Behavior disruptive of the functioning of the patient care unit;
4. Reasonable limitations on the number of visitors at any one time;
5. Patient’s risk of infection by visitors;
6. Visitor’s risk of infection by the patient;
7. Extraordinary protections because of a pandemic or infectious disease outbreak;
8. Substance abuse treatment protocols requiring restricted visitation;
9. Patient’s need for privacy or rest;
10. Need for privacy or rest by another individual in the patient’s shared room;
11. Any concern by the health care professional that visitation is not appropriate based upon the emotional and/or physical condition of the patient;
Resident Appointment and Reappointments

BAPTIST MEMORIAL HOSPITAL – MEMPHIS

GRADUATE MEDICAL EDUCATION

PROGRAM POLICY AND PROCEDURE MANUAL

Effective Date: January 2016
Last Review/Revision: February 2016
Reference #: -

Resident Selection Guidelines
Applicant Eligibility

PURPOSE: To establish a program-specific policy for resident selection that complies with the Accreditation Council for Graduate Medical Education (ACGME)

POLICY: Resident Selection Guidelines

PROCEDURE: The BMH – Memphis Family Medicine Residency Program Resident Selection Guidelines Applicant Eligibility Policy follows the BMH GME Departmental Policy with the following exceptions: Only applicants who are or will be within their initial residency period as defined by the Centers for Medicare & Medicaid Services (CMS) will be considered for positions in any ACGME-approved residency program in the Baptist Memorial Health Care system. Exceptions to this section of the Residency Selection Guidelines may be considered and approved by Baptist Memorial Health Care Graduate Medical Education Committee and Program on a case-by-case basis provided alternate funding can be secured by the applicant.

Applicants to the Baptist Memorial Hospital – Memphis Family Medicine residency program must meet the following standards to be eligible for consideration:

- Allopathic residents
  - USMLE Step I score of 200 or higher AND
  - USMLE Step II medical knowledge score of 200 or higher AND
  - USMLE Step II clinical skills pass without a previous fail
- Osteopathic residents may follow the above guidelines or
  - COMLEX Level I score of 440 or higher AND
  - COMLEX Level II CE score of 440 or higher
  - COMLEX Level II PE pass without a previous fail

Applicants with the following US Residency statuses will be considered for available residency positions within the MATCH:

- US Citizen
- Legal Permanent Resident (“Green card Holder”)
- Employment Authorization Document (EAD) resulting from application for Permanent Residency
- Foreign National with valid Visa permitting employment with Baptist
PURPOSE: To establish a policy for resident selection that complies with the Accreditation Council for Graduate Medical Education (ACGME) and American Osteopathic Association (AOA)

POLICY: Resident Selection Guidelines

PROCEDURE: Only the following individuals will be considered as applicants in residency and fellowship programs at Baptist Memorial Health Care Corporation:

ACGME-accredited Programs
- Graduate of Liaison Committee on Medical education (LCME)-approved U.S. and Canadian Medical Schools
- Graduates of American Osteopathic Association (AOA) accredited Osteopathic Medical Schools

AOA-accredited Programs
- Graduate of COCA-accredited (Commission on Osteopathic College Accreditation) medical schools
- International Medical Schools: International Medical Graduates must have valid Education Commission for Foreign Medical Graduates (ECFMG) certificate or a full and unrestricted license to practice medicine in a United States licensing jurisdiction in which they are in training
- Graduates of schools that are listed on the Medical Board of California “International Medical Schools Disapproved” List will not be considered for residency positions at Baptist Memorial Hospital – Memphis. This list can be found at http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Disapproved.aspx.

Only applicants who are or will be within their initial residency period as defined by the Centers for Medicare & Medicaid Services (CMS) will be considered for positions in any ACGME-approved residency program in the Baptist Memorial Health Care system. Exceptions to this section of the Residency Selection Guidelines may be considered and approved by Baptist Memorial Health Care Graduate Medical Education Committee on a case-by-case basis provided alternate funding can be secured by the applicant.

Applicants with the following US Residency statuses will be considered for available residency positions within the MATCH:
- US Citizen
- Legal Permanent Resident ("Green card Holder")
- Employment Authorization Document (EAD) resulting from application for Permanent Residency
- Foreign National with valid Visa permitting employment with Baptist
- J-1 visa through ECFMG

Application Process & Interviews
- All applications will be processed through the Electronic Residency Application Service (ERAS)
- Opportunities for interviews will be extended to applicants based on their qualifications as determined by citizenship/residency status as identified above, USMLE scores, medical school performance, letters of recommendation, and history of previous residencies/fellowships served.

National Resident Matching Program (NRMP) & Rank Order Process
- This program participates in the NRMP MATCH and will only consider applicants participating in the MATCH
- All eligible, interviewed applicants will be considered for ranking in the MATCH in order of preference based on the following criteria: preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.
- Characteristics such as gender, age, religion, color, national origin, disability or veteran status will not be used in the selection procedure. Baptist is an Equal Opportunity Employer.
- Recommendations of all interviewing faculty and residents will be considered in determining the rank order of the interviewed applicants.

Program Appointments
- Appointments to our programs will be issued to all matched applicants who meet eligibility requirements.
- Following release of the MATCH results, attempts will be made to fill any vacant positions in accordance with the terms of our agreement with the NRMP.
- Letters of Agreement for all positions will be issued through the Graduate Medical Education Office following a review of eligibility.

Exclusions
Residents must qualify for employment with Baptist Memorial Health Care. Some requirements for employment include a negative drug screen, clear criminal background check and the ability to participate in the federal programs (see additional info below). In addition, any residents who are required to obtain and maintain a medical license in the State of Mississippi must successfully complete Step III by the end of their PGY-2 year in order to maintain their eligibility for employment by BMHCC.

Baptist Memorial Hospital participates in the Office of Inspector General (OIG) and General Services Administration (GSA) Exclusion Programs. All names submitted to the NRMP are checked through the OIG and GSA to ensure that those individuals are not listed on the OIG "List of Excluded Individuals / Entities" or the GSA "List of Parties Excluded from Federal Procurement and Non-
procurement Programs.” The OIG list contains the names of parties convicted of “program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans.” The GSA list provides an up to date source of information on those firms and individuals that have been suspended, debarred or otherwise excluded from Federal Procurement and Non-procurement Programs. Baptist will not employ anyone who has been suspended, debarred or excluded from these programs.
<table>
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<th>Effective Date: July 2013</th>
<th>Resident Visa Policy</th>
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<tr>
<td>Last Review/Revision: May 2016</td>
<td>-</td>
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<tr>
<td>Reference #: -</td>
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**PURPOSE:** To establish a policy for resident visas that complies with the Accreditation Council for Graduate Medical Education guidelines

**POLICY:**
Resident Visa Policy

**PROCEDURE:**
Baptist will not petition for visas.
Objectives:

- To prohibit discrimination on the basis of individual’s race, color, religion, national origin, pregnancy, sex/gender, age, handicap, disability (physical, visual or mental), creed, marital status, veteran status, genetic information, or any other category protected by federal or state law in the hiring practices, and in all terms, privileges, or conditions of employment within Baptist.

- To recognize and promote management’s accountability in assuring a non-discriminatory work environment and to assure all employees that Baptist intends to treat them fairly during their employment.

- To provide an internal review mechanism for reporting alleged violations so that all complaints can be promptly investigated and resolved.

- To affirm the organization’s commitment to fair and consistent terms and conditions of employment without regard to an individual’s race, color, religion, national origin, pregnancy, sex/gender, age, handicap, disability (physical, visual or mental), creed, marital status, veteran status, genetic information, or any other category protected by federal or state law.

Policy:

I. **Commitment to Equal Employment Opportunity**

   It is the philosophy of the Organization to treat all employees fairly and with respect. Baptist is an Equal Opportunity Employer, and as such will not tolerate discrimination in the workplace with regard to individual’s race, color, religion, national origin, pregnancy, sex/gender, age, handicap, disability (physical, visual or mental), creed, marital status, veteran status, genetic information, or any other category protected by federal or state law. Baptist supports and adheres to all applicable state and federal regulations that prohibit discrimination relative to the terms, conditions, or privileges of employment. Additionally, Baptist is committed to provide reasonable accommodations to qualified individuals with disabilities as required by the Americans with Disabilities Act, as amended.

   Accordingly, discrimination in all terms, privileges, or conditions of employment, including but not limited to recruiting, hiring, placement, training, transfer, promotion, rates of pay, and other compensation, is strictly prohibited by Baptist.
II. **Harassment**  
Harassment in any form is not tolerated by Baptist (refer to Harassment Policy).

III. **Responsibility of Management**  
Management/supervisory staff members have the responsibility and obligation to provide equitable, non-discriminatory and non-offensive work environments for all employees.

IV. **Complaints of Harassment or Discrimination**  
Baptist strongly encourages all employees who have experienced, witnessed, or have knowledge of any form of harassment or discrimination by anyone, including employees, managers, supervisors, students, physicians, customers, visitors, patients, vendors, service providers, etc., to report such harassment or discrimination immediately to their immediate supervisors, a member of the management team, or human resources.

Once an employee reports an alleged violation, whether it is reported to the employee’s immediate supervisor, another member of the management team, and/or the human resources department, human resources is responsible for conducting a prompt, thorough internal investigation. The investigation will be fair and impartial to all parties involved. Any harassment or discrimination complaint should specifically state the details of the offending behavior.

During the investigation, an employee who has made a harassment or discrimination complaint may be asked to document in writing specific details relating to the complaint. Harassment or discrimination complaints will be handled with as much confidentiality as possible. Baptist will seek to limit disclosure to the extent necessary to conduct a complete and thorough investigation or as may be necessary to take appropriate corrective action. In reporting an alleged violation, it is important that colleagues are both truthful and factual in their written and verbal communication about claim of discrimination or harassment.

Complaints of harassment or discrimination receive a review up to the appropriate administrative staff member. Employees should contact the human resources department for information regarding this review procedure.

If it is determined that no harassment or discrimination has occurred, or there is not sufficient evidence to make a decision regarding the complaint, this determination will be communicated to the employee who made the complaint.

V. **Retaliation**  
Baptist will not tolerate retaliation against any employee who reports a claim of discrimination in good faith or against any employee who provides information as a witness to the discrimination. Retaliation will result in disciplinary action up to and including discharge.

VI. **Policy Violations**  
If an investigation confirms that a violation of policy has occurred, the Organization will take corrective action to effectively end the discrimination. Depending on the circumstances, such action may include coaching or other disciplinary action up to and including termination of employment. As necessary, Baptist may monitor any incidence of discrimination to ensure the discriminatory behavior has stopped. In all cases, Baptist will follow up as necessary to ensure no retaliation has occurred for making a complaint or cooperating with an investigation.
PURPOSE: To establish a program-specific policy for academic due process that complies with the Accreditation Council for Graduate Medical Education guidelines

POLICY: Resident Evaluation, Promotion and Discipline Policy

PROCEDURE: The BMH – Memphis Family Medicine Residency Program Resident Evaluation, Promotion and Discipline Policy follows the BMH GME Departmental Policy with the following exception:

RESIDENT REAPPOINTMENT / PROMOTION

Reappointment and promotion to the subsequent year of training require satisfactory progress in scholarship and professional growth as indicated by cumulative evaluations by faculty. This includes demonstrated proficiency in:

1. Patient Care
2. Medical Knowledge – see below for minimal requirements for advancement to the next PGY level
   o PGY-1 to PGY-2: ITE score of at least five (5) percent higher on the PGY-1 exam when compared to the practice test given during Program Orientation. Exception: PGY-1 residents scoring in the top 40% of the national cohort or higher on their PGY-1 ITE exam are exempt from this requirement.
   o PGY-2 to PGY-3: ITE score of at least five (5) percent higher on the PGY-2 exam when compared to the PGY-2 exam. Exception: PGY-1 residents scoring in the top 30% of the national cohort or higher on this exam are exempt from this requirement.
3. Practice-Based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism – see below for required Likert scoring in this area on the Global Summative Evaluation as approved by the Clinical Competency Committee and Program Director for advancement to the next PGY level
   o PGY-1 to PGY-2: Minimal Likert score of 2.0, documented participation in a Quality Improvement or Patient Safety activity, and documented attendance of at least 75% of all didactic activities for this academic year in compliance with ACGME requirements
   o PGY-2 to PGY-3: Minimal Likert score of 3.0, documented participation in a Quality Improvement or Patient Safety activity, and documented attendance of at least 75% of all didactic activities for this academic year in compliance with ACGME requirements
   o PGY-3 to Completion certificate: Minimal Likert score of 4.0 and fulfillment of all program requirements including completion of two scholarly activities
6. Systems-Based Practice

In addition, all residents must accomplish and maintain the following:

- ACLS Certification if required by Program
- Mississippi Licensure if required by Program
- All requirements as Baptist employees including but not limited to:
  - Annual competency education (HealthStream)
  - Employee Health Requirements (TB, Flu, etc.)
  - BLS Certification
PURPOSE: To establish a policy for academic due process that complies with the Accreditation Council for Graduate Medical Education guidelines

POLICY: Resident Evaluation, Promotion and Discipline Policy

RESIDENT EVALUATION
Residents will be evaluated following each rotation. Evaluations are completed electronically via New Innovations and reviewed by the Clinical Competency Committee (CCC) (see below) in preparation for the resident's semi-annual review. The Program Director will meet with each resident during their semi-annual review during which time evaluations and the report from the CCC will be reviewed. Program goals and objectives are also discussed during this time. The semi-annual review report is then signed and placed in the resident's file. Residents may review their files upon request.

CLINICAL COMPETENCY COMMITTEE (CCC)
The Clinical Competency Committee is composed of three members of the program faculty. Other faculty members may be selected if appropriate from other programs. The Program Director acts as the non-voting Chair of this committee. The duties and responsibilities of this committee will include:

- Review all resident evaluations semi-annually;
- Prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and,
- Advise the Program Director regarding resident progress, including promotion, remediation, and dismissal.

RESIDENCY PROGRAM
Each program must ensure that the Faculty evaluate resident performance in a timely manner during each rotation or similar educational assignment and provide documentation of the evaluation at the completion of the assignment. Additional duties and responsibilities of the Program include:

- Provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;
- Use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
• Document progressive resident performance improvement appropriate to educational level; and,
• Provide each resident with documented semiannual evaluation of performance with feedback.

SUMMATIVE EVALUATION
The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. The program director must provide a summative evaluation for each resident upon completion of the program.

This evaluation must:
• Become part of the resident’s permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;
• Document the resident’s performance during the final period of education; and,
• Verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

RESIDENT REAPPOINTMENT / PROMOTION
Reappointment and promotion to the subsequent year of training require satisfactory progress in scholarship and professional growth as indicated by cumulative evaluations by faculty. This includes demonstrated proficiency appropriate for the current program year in each of the ACGME Competencies listed below and most of the corresponding Milestones:

7. Patient Care
8. Medical Knowledge
9. Practice-Based Learning and Improvement
10. Interpersonal and Communication Skills
11. Professionalism
12. Systems-Based Practice

In addition, all residents must accomplish and maintain the following:
• ACLS Certification if required by Program
• Mississippi Licensure if required by Program
• All requirements as Baptist employees including but not limited to:
  o Annual competency education (HealthStream)
  o Employee Health Requirements (TB, Flu, etc.)
  o BLS Certification

DISCIPLINARY ACTIONS
Academic, performance, and professional deficiencies as well as related remediation and consequences are discussed with each resident when appropriate. Disciplinary policies are typically utilized for serious acts requiring immediate action. These policies include the following:

- GME / Due Process
- GME / Nonrenewal of Agreements Policy
- BMH / Additional policies available online
PURPOSE: To establish a policy clarifying resident requirements for advancement in salary level.

POLICY: Resident Salary Policy

PROCEDURE: Residents will be paid according to post-graduate year (PGY) level with exceptions made only as described in this policy or in the policy concerning Due Process. It is the intent of this policy that actual salary amounts will be adjusted to include health/dental insurance premiums so that net income will be equivalent for each resident in that PGY level after insurance premiums are deducted. Some minor variance in net paid amounts may result.

REQUIREMENTS FOR ADVANCEMENT:

Incoming Residents
Incoming residents must submit a signed Residency Agreement to the program at least thirty (30) days before the beginning of the residency period. Incoming residents must present copies of their official USMLE Step or COMLEX scores, medical school and intern completion certificates (or letter of completion), and current BLS certification to the GME Office by the first day of residency. Fire Safety documentation and Employee Handbook acknowledgement will be completed during Program Orientation. Residents who do not comply with these requirements will be paid at a lower PGY level until such time as they are current. For example, residents at PGY-2 level who do not present this documentation will be paid at the PGY-1 level until they fulfill these requirements. Pay level increases for residents who are late submitting this information will start at the beginning of the pay period following receipt of all documentation.

- Thirty days before beginning residency
  - Residency Agreement
- Two weeks before beginning residency
  - USMLE Step or COMPLEX scores
  - Medical School Graduation Certificate
  - Current BLS certificate
  - Pre-employment health screening as determined by Employee Health
- First day of program orientation
  - BMHCC and Program required documentation
Employee Handbook acknowledgement

- Within thirty days after beginning of residency (NOTE: Residents who fail to fulfill these requirements are subject to disciplinary action up to and including dismissal)
  - Intern-year Completion Certificate or Program Completion Letter from the previous program's Program Director if appropriate
  - Completion of Mandatory Education Modules (HealthStream) and Respiratory Fit Testing
  - Second (2nd) TB skin test if appropriate

Returning Residents
Returning residents must submit a signed Residency Agreement to the program at least thirty (30) days before the beginning of the residency period. An annual TB skin tests or chest X-Ray, as determined by Employee Health, is required. Completion of annual training requirements as stated below is also required for salary advancement. Residents who do not comply with these requirements will be paid at a lower PGY level until such time as they are current. For example, residents at PGY-3 level who did not complete the annual mandatory HealthStream modules will be paid at the PGY-2 level until these modules are completed. Pay level increases for residents who complete all requirements within the appropriate time frame will be effective on July 1 or at the beginning of the pay period preceding the beginning of the new academic year. Pay level increases for residents who are late submitting this information will start at the beginning of the pay period following receipt of all documentation. NOTE: In addition to the consequences included in this policy, residents who are delinquent in the fulfillment of these requirements are subject to disciplinary action up to and including dismissal.

Osteopathic residents cannot and will not enter OGME-3 without the successful completion of COMLEX part 3.

Additionally, each resident must demonstrate successful achievement of most ACGME Milestones appropriate for the resident's current Post-Graduate Year level as determined by the Clinical Competency Committee and documented in the resident's file.

All residents are required to be in compliance with all hospital policies concerning the following:

- BLS / ACLS certification
- Computer-based learning activities (HealthStream)
- TB skin test (when available)
- Flu vaccinations or completion of declination form
- Employee Handbook acknowledgement
- Residency Agreement
- Annual respiratory Fit Testing
- Radiation Safety

Residents whose BLS certification has expired or who are found to be delinquent in the completion or maintenance of the above requirements including Milestones will not be eligible for the annual PGY-level pay increase until such time as all requirements have been fulfilled. For residents who are delinquent in any of the above requirements, PGY-level pay increases will start at the beginning of the pay period following completion of these requirements and receipt of all supporting documentation.
Nonrenewal of Agreements

PURPOSE: To establish a Nonrenewal of Agreements policy that complies with Accreditation Council for Graduate Medical Education and Baptist Memorial Hospital guidelines

POLICY: Nonrenewal of Agreements Policy

PROCEDURE: If a Residency Program decides not to renew a resident's agreement, the resident will be notified in writing no later than four months prior to the end of the resident's current contract. If the decision of nonrenewal occurs within four months prior to the end of the agreement, programs must provide the resident with as much written notice as possible.

If a resident cannot fulfill the requirements of the Program to advance to the next level, the resident's agreement may not be renewed. For example, if the resident cannot submit documentation of the successful completion of the USMLE Step III test before the end of his/her PGY-2 year, the resident's agreement may not be renewed.

Residents must be allowed to implement the institution's Due Process Procedure when they receive a written notice of intent not to renew their agreement.
Sample Agreement

RESIDENT SERVICES EMPLOYMENT AGREEMENT

THIS AGREEMENT is effective as of the 1st day of July, 2016, by and between Baptist Memorial Hospital, a Tennessee not-for-profit corporation hereafter referred to as “Baptist”, and «First» «Last», M.D., hereinafter referred to as “Resident.”

WHEREAS, Baptist provides health care in Shelby County, Tennessee on a not-for-profit basis consistent with Section 501(c)(3) of the Internal Revenue Code of 1986, and recognizes that needed physicians must be attracted to and retained in the community to provide health care services in and through affiliated hospitals, facilities, and clinics;

WHEREAS, Resident is statutorily qualified to practice as a resident in the State of Tennessee and is qualified to perform the services required by this Agreement;

WHEREAS, Baptist has determined that its employment of Resident will contribute to the quality of health care within Baptist’s service area and thereby promote its charitable purpose;

THEREFORE, in consideration of the mutual promises hereafter contained, it is agreed:

1. EMPLOYMENT. Baptist hereby employs Resident to provide resident services at Baptist Memorial Hospital – Memphis, Women’s and Collierville campuses as applicable and such other locations designated by Baptist and Resident accepts such employment subject to the terms and conditions set forth in this Agreement.

2. TERM. The term of this Agreement shall be one (1) year, commencing on July 1, 2016.

3. RESIDENT’S OBLIGATIONS.

3.1. Devotion of Time and Practice Relationships. Resident agrees to devote time and practice according to the terms of Exhibit A of this Agreement.

3.2. Membership Requirements. Resident agrees to obtain resident membership on Baptist’s medical staff and other organizations according to the terms of Exhibit A of this Agreement.

3.3. Application Requirements. In order for Resident to perform professional services as required by Baptist in this Agreement, Resident acknowledges and agrees that certain application requirements should be timely and accurately met by Resident prior to the start date of the initial term of this Agreement. In order for Baptist to provide professional liability insurance and for Baptist to begin paying Resident for resident services, Resident must complete Baptist’s minimum application requirements, as separately provided by Baptist, at least thirty (30) days prior to the start date of this Agreement. Resident further acknowledges that Baptist may require additional information beyond its minimum requirements, and Resident agrees to timely and accurately provide such information by the date(s) requested by Baptist. In the event Resident cannot meet these application requirements by the date listed above, Resident shall notify Baptist in writing, in accordance with Section 10 of this Agreement, of the specific application items to be outstanding, any reasons for delay, and any problems with the application process. Resident hereby affirms that any information submitted in Baptist’s application process shall be true and complete to the best of Resident’s knowledge, and Resident shall have an ongoing obligation to inform Baptist immediately upon becoming aware of any material change in Resident’s application information.

3.4. Professional Standards. Resident shall, at all times, comply with the rules and regulations adopted by Baptist applicable to resident training and the applicable rules, regulations and standards of the Accreditation Council for Graduate Medical Education, the Joint Commission, the Medicare Conditions of Participation and any other applicable state or federal law.
3.5. **Licensure and Board Certification.** Once achieved, Resident shall remain statutorily qualified to practice medicine as a resident in the States of Tennessee.

3.6. **Quality Assessment and Peer Review.** Resident shall be subject to and, to the extent requested by Baptist, participate in quality assessment, utilization management, and peer review procedures established by Baptist.

3.7. **Confidential Information.** Resident shall not disclose Baptist's confidential information, during the term of this Agreement or at any point in the future, unless required by law, regulation, medical staff bylaw, or by the terms of any applicable contract for reimbursement. Confidential information includes both the information contained within this Agreement and any information related to Baptist's business affairs and operations, including but not limited to the details on any contracts negotiated by Baptist, patient names, patient lists/databases, and computer software applications. In addition to all other available remedies, Baptist shall be entitled to injunctive relief enjoining physician from disclosing any such confidential information or providing services to a party for whom such information has been or may be disclosed.

3.8. **Freedom to Perform.** Resident represents and warrants that there are no restrictions, non-competition agreements, or other obligations which would interfere with or restrict the performance of Resident’s services required in this Agreement. Furthermore, Resident represents and warrants that any and all ongoing, pending, threatened, or potential malpractice claims have been fully disclosed in writing to Baptist.

3.9. **Services to be Provided in a Non-Discriminatory Manner.** Resident shall provide all resident services in a non-discriminatory manner without regard to race, color, national origin, gender, age, or handicapping condition.

3.10. **Baptist’s Policy regarding Discrimination.** Resident shall comply with Baptist's policy regarding discrimination (as may be amended from time to time by Baptist) including, without limitation, acting in a non-discriminatory manner towards all individuals and entities on the basis of employment, race, religion, national origin, gender, handicap, disability, and/or sexual harassment.

3.11. **Professional Malpractice Coverage and Other Liability Coverage.** Resident shall meet all qualifications to participate in Baptist's professional malpractice insurance coverage or programs of self-insurance and any other liability policies, coverages, or programs of self-insurance designated by Baptist, and Resident shall attend educational activities to reduce liability insurance costs as reasonably requested by Baptist. Resident shall immediately notify Baptist, in writing, of any action taken to limit, suspend, revoke, or otherwise restrict Resident's malpractice insurance or coverages or of any investigation which may lead to an action to revoke, suspend, or impose any limitation respecting the same. Resident specifically acknowledges and agrees that the malpractice insurance coverage provided hereunder will only cover allegations of professional negligence arising as a result of training activities under this Agreement. Should Resident be allowed to engage in other employment as described in Section 6 below, then it shall be Resident’s responsibility to secure separate coverage for the other employment at Resident’s expense.

3.12. **Referrals not Required:** Both parties acknowledge and agree that neither this Agreement nor the compensation paid hereunder is based on, takes into account, or is contingent upon Resident referring patients to an entity affiliated with Baptist.

3.13. **Resident Participation.** Resident shall actively participate and assist Hospital in connection with, but not limited to, preparation for Joint Commission and any other regulatory surveys, utilization review activities, drafting, revising and improving Medical Staff Bylaws, Medical Staff Quality Improvement meetings, hospital quality improvement meetings, identification of ways to reduce patient’s length of stay, expected mortality meetings, marketing and public relations matters related
to patient satisfaction meetings, patient safety meetings, Institute for Healthcare Improvement ("IHI")/Spread activities and establishment of appropriate clinical protocols for the Specialty Program.

4. BAPTIST'S OBLIGATIONS.

4.1. **Compensation.** Baptist agrees to pay Resident for all services rendered by Resident under this Agreement according to the terms of Exhibit B.

4.2. **Benefits.** Baptist agrees to provide benefits to Resident according to the terms of Exhibit C.

4.3. **Baptist shall provide Professional Malpractice Coverage.** Baptist will arrange and pay professional malpractice insurance coverage or similar coverage through a group plan or a plan of self-insurance for Resident for the term of employment, with liability limits of at least one million dollars ($1,000,000) per occurrence/three million dollars ($3,000,000) annual aggregate or the amounts, if greater, required by the medical staff bylaws of hospitals designated by Baptist.

4.4. **Working Facilities.** Baptist shall provide Resident with such office space, staff, supplies, equipment, and services as reasonably necessary for the performance of Resident’s duties.

4.5. **Baptist Policies.** All policies, including those concerning Disruptive Behavior; Resident Evaluation, Promotion, and Discipline; Program Closure / Reductions; Resident Health (Impairment); Leaves of Absence (including vacation, parental, and sick leave as well as the effect of leave on program completion); Duty Hours; and Moonlighting shall be provided to the Resident both in writing and electronically.

4.6. **Eligibility for Specialty Board Examinations.** Eligibility of residents / fellows for specialty board examinations should be discussed with the resident by the Program Director. For specific requirements, residents should contact the specialty boards.

5. FEES, CONTRACTING, BILLING, AND COLLECTIONS.

5.1. **Rights to Fees.** Resident specifically agrees that Baptist shall have the right to determine reasonable fees to be charged by Baptist for medical services rendered by Resident. All fees, revenues, or payments generated by Resident from professional services, including all fees for service, office visits, hospital rounds, emergency department visits, consultations, home health visits, fees for medical directorships, income from reading, testing, income from duties performed pursuant to a contract (i.e. employee physicals), physician coverage of hospital emergency departments, and income from expert testimony, shall be for the benefit and sole property of Baptist unless otherwise assigned to another party.

5.2. **Contracting, Billing, and Collections.** It is agreed that Resident shall have no authority to act on behalf of or bind Baptist with respect to any contract or agreement. Resident hereby appoints Baptist as attorney-in-fact with respect to all contracting, billing, and collection matters to the full extent authorized by law, including the unlimited authority to enter into managed care agreements and oversee the administration of such agreements. Resident shall not submit any separate or independent billings to patients, public or private third party payors or other responsible parties.

6. OTHER EMPLOYMENT AND ACTIVITIES. Resident agrees to practice exclusively for, and at the location(s) specified, by Baptist. Except as permitted by the Baptist Memorial Health Care Graduate Medical Education Moonlighting Policy, Resident shall not provide any medical services, either directly or indirectly, in any manner with any person or entity other than Baptist. Resident acknowledges that violation of this provision will subject Resident to disciplinary action, up to and including dismissal from the Program.
7. TERMINATION.

7.1. By Baptist With Cause. This Agreement may be terminated immediately for cause by Baptist upon written notice to Resident. The reasons that Baptist may terminate this Agreement with cause include, but are not limited to, the following:

7.1.1. Resident’s abuse of alcohol and/or drugs.

7.1.2. Resident’s failure to qualify for or maintain statutory qualifications to practice as a resident physician in the States of Tennessee; Resident's failure or inability to perform required medical duties as a result of the revocation, cancellation, suspension, or restriction of Resident's statutory qualifications to practice as a resident physician in the States of Tennessee or, Resident's failure or inability to perform required medical duties as a result of any other action by a governmental, professional, or similar organization having jurisdiction over Resident’s practice of medicine.

7.1.3. Termination or restriction of Resident’s resident membership/clinical privileges at Baptist.

7.1.4. Any act(s) by Resident constituting a misdemeanor or felony.

7.1.5. Resident’s failure to qualify for or maintain qualifications for malpractice insurance coverage required by this Agreement.

7.1.6. Upon material violation by Resident of any provisions of this Agreement or the rules, policies, and/or procedures of Baptist and/or Hospital.

7.1.7. Upon repeated failure by Resident to meet utilization, performance, efficiency, or quality standards established by Baptist.

7.1.8. Upon conduct by Resident which is considered by Baptist to be unethical, unprofessional, fraudulent, unlawful, or adverse to the interest, reputation or business of Baptist.

7.1.9. Upon total disability of Resident or upon inability of Resident to perform the duties required hereunder for a designated period of time in accordance with applicable law and Baptist’s employment policies and procedures.

7.1.10. Upon repeated failure by Resident to conform and comply with Baptist’s professional requirements concerning maintenance of medical records.

7.1.11. Upon the determination of Baptist in good faith that Resident is not providing adequate patient care or that the health, safety or welfare of patients is jeopardized by continuing the employment of Resident.

7.1.12. Upon exclusion of Resident from participation in federal health care programs.

8. EVENTS FOLLOWING TERMINATION.

8.1. Return of Baptist's Property. Upon termination, Resident shall immediately return any and all property of Baptist including, but not limited to, keys, card keys, identification badges or other security devices used by Resident. Furthermore, Resident shall vacate the practice site on the date specified by Baptist and remove all personal effects by that date. Any personal property not removed shall be deemed abandoned by Resident and may be disposed of at Baptist’s discretion.

9. AGREEMENTS REGARDING PATIENTS AND PATIENT RECORD.
9.1. **Baptist's Patients.** Upon termination or non-renewal of this Agreement, Resident shall not contact any patients without Baptist's permission.

9.2. **Patient Confidentiality.** Any patient information received by Resident is privileged and shall not be disclosed except as required or permitted by law. Any disclosure made without the patient's express written permission must be made according to applicable legal requirements and Baptist’s rules and regulations. This provision shall survive the termination or expiration of this Agreement.

9.3. **Patient Records.** All records, including regular and personal files, of patients treated, consulted, served, or interviewed by Resident shall belong to and remain the property of Baptist and may be removed only upon its written consent. Resident shall maintain current, accurate, and complete patient records which comply with both governmental and Baptist record keeping requirements. The use and copying of patient records shall be subject to Baptist’s permission and conducted according to its rules and regulations.

10. **NOTICES.** All notices, requests, demands, and other communications required or permitted to be in writing and sent by certified first class mail, postage prepaid, return receipt requested, to:

   Resident: «First» «Last», M.D.
   «Street_Address»
   «City», «State» «Zip»

   Baptist: Baptist Memorial Hospital – Memphis
   6019 Walnut Grove Road
   Memphis, Tennessee 38120
   Attn: Administrator and CEO

   Either party may change said address by giving written notice to the other.

11. **ENTIRE AGREEMENT, ASSIGNMENT, AND WAIVER.**

   11.1. **Governing Law.** This Agreement shall be governed by and construed under the laws of the State of Tennessee without reference to the principles of choice and/or conflict of law.

   11.2. **Entire Agreement and Amendment.** This Agreement and its Exhibits constitute the final and complete agreement of the parties and supersedes any previous agreement, promise, negotiation, or representation concerning the subject matter of this Agreement. This Agreement is not being entered into on the basis of or reliance on any promise or representation other than the promises specifically and expressly set forth herein. This Agreement may not be modified or amended except by an instrument in writing signed by the parties hereto.

   11.3. **Assignment.** This Agreement and all rights and obligations of Resident hereunder are personal to Resident and shall not be voluntarily or involuntarily sold, transferred, or assigned by Resident. Baptist may assign this Agreement and any or all of its rights, interests, and obligations hereunder to any entity affiliated or associated with Baptist.

   11.4. **Waiver.** No term or condition of this Agreement shall be deemed waived nor shall there be an estoppel against the enforcement of any provision of this Agreement except by written instrument signed by the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated.

   11.5. **Non-Waiver Breach.** Failure to enforce any of the terms and conditions in this Agreement in a particular circumstance shall not be construed as a general waiver or continuing waiver thereof by
Baptist. Baptist shall be free to reinstate such term or condition with or without notice to Resident, unless and except to the extent that such waiver is provided in writing.

12. MEDICARE ACCESS TO BOOKS AND RECORDS. In the event that Section 952 of the Omnibus Reconciliation Act of 1980, 42 U.S.C. § 1395x(v)(1)(I), is applicable to this Agreement, Resident agrees with Baptist that until the expiration of four (4) years after the furnishing of the services provided under this Agreement, Resident will make available to the Secretary of the United States Department of Health and Human Services (the "Secretary") and the United States Comptroller General, and their duly authorized representatives, this Agreement and all books, documents, and records necessary to certify the nature and extent of the costs of these services. If Resident carries out the duties of this Agreement through a subcontract, it will also contain an access clause to permit access by the Secretary, the United States Comptroller General, and their representatives to the related organization's books and records. If Baptist is caused a loss of reimbursement or otherwise penalized by reason of Resident's failure to cooperate under this section, Resident will be responsible for such loss.

13. SEVERABILITY. If any provision of this Agreement is held invalid for any reason, such invalidity shall not affect any other provision of this Agreement.

14. EXCLUSION/DEBARMENT.

14.1. Glossary, for purposes of this provision:

14.1.1. "Ineligible to participate in Federal programs" means to have been excluded, debarred, suspended or otherwise declared ineligible to participate in Federal health care programs or Federal procurement or non-procurement programs.

14.1.2. "Designated crimes" means program-related crimes; crimes relating to patient abuse; felony conviction relating to health care fraud; or felony conviction relating to controlled substances.

14.2. Resident warrants that Resident is not currently ineligible to participate in Federal programs nor has he/she been convicted of any of the designated crimes. If Resident is declared ineligible to participate in Federal programs or is convicted of any of the designated crimes, Resident agrees that he/she will immediately notify Baptist of the ineligibility or conviction, and Resident furthermore agrees that such ineligibility or conviction shall provide a basis for the immediate termination of this Agreement.

14.3. In the event that Resident is ineligible to participate in Federal programs or is convicted of any of the designated crimes, and such ineligibility or conviction results in Baptist being unable to bill for such goods, services and/or products or having to reimburse payment received, then Resident agrees to reimburse Baptist for the amount that could not be billed or that had to be reimbursed for such goods, services and/or products, plus any interest incurred and any financial penalties imposed that are the direct result of such ineligibility or conviction.

14.4. Resident hereby represents and warrants that he/she has not been charged with, arrested for or convicted of any sex offenses and that at no time has he/she been listed in 1) the national sex offender public registry website coordinated by the United States Department of Justice; 2) the sexual offender registry maintained by the Arkansas Crime Information Center; 3) the sexual offender registry maintained by the Mississippi Department of Public Safety; or 4) the sexual offender registry maintained by the Tennessee Bureau of Investigation.

14.5. Resident hereby represents and warrants that he/she has not been charged with, arrested for or convicted of any offenses related to abuse and that at no time has he/she been listed on any adult abuse registry maintained for any state in which Resident has lived in the previous seven (7) years including, but not limited to, that maintained by the Tennessee Department of Health.
15. STANDARDS OF CONDUCT. Resident has received a copy of the Baptist Standards of Conduct, has read them and agrees to abide by them as a condition of employment with Baptist. Resident agrees to sign the acknowledgement contained in the back of the Standards of Conduct and return it prior to beginning to perform under this Agreement. If Resident becomes aware of any suspected violation of laws, regulations, or Baptist Standards of Conduct during the term of this Agreement, Resident agrees to report such to Baptist through the facility’s Compliance Coordinator and/or Officer, the Baptist Helpline/Hotline, Baptist Corporate Compliance or Baptist Corporate Legal Counsel.

16. COMPLIANCE WITH APPLICABLE LAWS.

16.1. The parties expressly acknowledge that it has been and continues to be their intent to comply fully with all applicable federal, state, and local laws, rules, and regulations. It is neither a purpose nor a requirement of this Agreement or any other agreement between the parties to offer or receive any remuneration or benefit of any nature for the referral of, or to solicit, require, induce, or encourage the referral of any patient, item, or business for which payment may be made or sought in whole or in part by Medicare, Medicaid, or any other federal or state reimbursement program. This Agreement has been prepared to comply, to the extent possible, with all applicable Safe Harbor regulations and to comply with the Stark Law and all rules and regulations thereunder. All compensation and payments provided hereunder are intended to represent fair market value for the services provided and it is expressly acknowledged that no payment made or received under this Agreement is in return for the referral of patients or in return for the purchasing, leasing, ordering, arranging for, or recommending the purchasing, leasing, or ordering of any good, service, item, or product for which payment may be made or sought in whole or in part under Medicare, Medicaid, or any other federal or state reimbursement program. In the event of any applicable legislative or regulatory change or action, whether federal or state, that has or would have a significant adverse impact on either party hereto in connection with the performance of services hereunder, or should either party be deemed for any reason in violation of any statute or regulation arising from this Agreement, or should it be determined that this Agreement gives rise to a financial relationship or other relationship under the Stark Act which is not subject to an applicable exception so that referrals between the parties, or billing for such referrals, would be prohibited or restricted by the Stark Act or other state or federal “anti-referral” law, then this Agreement shall be renegotiated to comply with the then current law and, if the parties hereto are unable to reach a mutually agreeable and appropriate modification, either party may terminate this Agreement upon ninety (90) days written notice to the other party.

16.2. The parties acknowledge that in the event Resident has multiple contracts with Baptist, all such contracts shall be memorialized in Baptist’s TractManager contract management system which shall serve as Baptist’s “master list” as required by 42 C.F.R §411.357(d).

SIGNATURES APPEAR ON THE NEXT PAGE

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the date first above-written.

Baptist Memorial Hospital
By: ______________________________

Randy King

Its: Vice President Metro Operations

Resident

By: ______________________________
Family Medicine (ACGME # 1204700727)
Anne L. S. Sullivan, MD, FAAFP; Program Director
Kent A. Lee, MD, FAAFP; Clinical Associate Program Director
4 resident physicians (4/0/0)
BMH / CH Family Medicine Program Structure

Academic Year 2016 – 2017
Family Medicine Chain of Command

Family Medicine (ACGME # 1204700727)

- Anne L. S. Sullivan, MD, FAAFP; Program Director
- Kent A. Lee, MD, FAAFP, MA; Clinical Associate Program Director
- Ron McDonald, DMin; Core Faculty (Behavioral Health)
- Susan Nelson, MD, FAAFP; Core Faculty (FMP)
- Collins Rainey, MD, FAAFP; Core Faculty (FMP)
- Regina Neal; Program Coordinator
Graduate Medical Education Committee (GMEC)

In compliance with Accreditation Council for Graduate Medical Education (ACGME) and Baptist Memorial Health Care (BMHCC), the Graduate Medical Education Committees at BMHCC facilities are established according to the following guidelines.

ACCREDITATION STANDARDS

ACGME:

- Voting membership must include:
  - Designated Institutional Official (DIO)
  - A representative sample of program directors from the institution’s ACGME-accredited programs (or program director from single program if institution has only one program)
  - At least two peer-selected residents/ fellows from among the institution’s ACGME-accredited programs (or sole resident/ fellow from sole program if applicable)
  - A quality improvement or patient safety officer or designee
  - For single program institutions, one or more individuals from a different department than that of the program specialty (and other than the quality improvement or patient safety member), within or from outside the Sponsoring Institution, at least one of whom is actively involved in graduate medical education

- Subcommittees that address required GMEC responsibilities must include a peer-selected resident/ fellow

- Subcommittee actions that address required GMEC responsibilities must be reviewed and approved by the GMEC

- GMEC must meet at least once per quarter during each academic year and must include attendance by
  - at least one resident/ fellow member
  - at least one Quality Improvement / Patient Safety representative
  - at least one member of the Graduate Medical Education department
  - The DIO or his/her designee
  - at least one Program Director or Program Faculty member from at least 50% of the programs of the Sponsoring Institution

- Meeting minutes must be kept for each GMEC meeting and include documentation of execution of all required GMEC functions and responsibilities which include:
  - Oversight of:
    - ACGME accreditation status of the Sponsoring institution and each of its ACGME-accredited programs
    - The quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs and its participating sites
    - The quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and Specialty/ subspecialty-specific Program Requirements
    - The ACGME-accredited program(s)’ annual evaluation and improvement activities and
    - All processes related to reductions and closure of individual ACGME-accredited programs; major participating sites, and the Sponsoring Institution
Review and approval of:

- Institutional GME policies and procedures
- Annual recommendations to the Sponsoring Institution’s administration regarding resident/fellow stipends and benefits
- Applications for ACGME accreditation of new programs
- Requests for permanent changes in resident/fellow complement
- Major changes in each of its ACGME-accredited programs’ structure or duration of education
- Additions and deletions of each of its ACGME-accredited programs’ participating sites
- Appointment of new program directors
- Progress reports requested by a Review Committee
- Responses to Clinical Learning Environment Review (CLER) reports
- Requests for increases or any change to resident duty hours
- Voluntary withdrawal of ACGME program accreditation
- Requests for appeal of an adverse action by a Review Committee and
- Appeal presentations to an ACGME Appeals Panel.

- The GMEC must demonstrate effective oversight of the Sponsoring Institution’s accreditation through an Annual Institutional Review (AIR)
  - The GMEC must identify institutional performance indicators for the AIR which include:
    - Results of the most recent institutional self-study visit
    - Results of ACGME surveys of residents/fellows and core faculty members and
    - Notification of each of its ACGME-accredited programs’ accreditation statuses and self-study visits
  - The AIR must include monitoring procedures for action plans resulting from the review
  - The DIO must submit a written annual executive summary of the AIR to the Governing Body

- The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process
  - The Special Review process must include a protocol that:
    - Establishes criteria for identifying underperformance and
    - Results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.

The Graduate Medical Education Committee is well established at BMHCC. This committee is comprised of residents, medical staff, quality and patient safety, and administrative representatives from all Baptist facilities involved in Graduate Medical Education. Additional representatives from our affiliated institutions also serve on the Baptist GMEC. The GMEC reports to BMHC Medical Executive Committee (MEC). Ultimate oversight for GME is provided by the Baptist Board of Directors.

The BMHC GMEC meets every other month and is responsible for the oversight of graduate medical education at all Baptist facilities. This committee provides oversight for all annual program reviews, special reviews, and GME policy administration. The committee is led by the Director of Graduate Medical Education (DGME) which is currently filled by the ACGME Designated Institutional Official (DIO)/Chief Academic Officer (CAO) for Baptist Memorial Health Care who reports to the Chief Medical officer for Baptist Memorial Health Care. The DGME reports bimonthly to the Graduate Medical Executive Committee (GMEC) to communicate issues of patient safety, quality, educational, and supervisory needs.
of the education programs. This information is communicated in turn to the Board of Directors as a part of the report of the GMEC.

Each facility that sponsors a GME Residency Program maintains its own GMEC. Representatives from all facilities hosting residents and medical students are invited to serve on the BMHC GMEC via teleconferencing.

Current membership on the BMHC GMEC includes the following positions:

- DGME/ DIO/ Chief Medical Officer
- Baptist Program Directors, Associate Program Directors, and Program Coordinators
- Baptist Peer-selected Resident Representatives
- Faculty/ Site Directors from UTHSC
- Resident Representatives from UTHSC
- Patient Safety/ Quality/ Performance Improvement Representative
- Graduate Medical Education Representative
- Finance/ Reimbursement
- Pending Program Representatives
Chief Academic Officer (CAO)
The Chief Academic Officer for Baptist Memorial Health Care provides oversight for Medical Education, Graduate Medical Education, and Continuing Medical Education for all facilities in the BMHCC system. The CAO reports to the Corporate Chief Medical Officer.

The CAO’s responsibilities related to Graduate Medical Education include the following:

1. Provide administration for Graduate Medical Education and oversight for all submissions to the Accreditation Council for Graduate Medical Education (ACGME) and American Osteopathic Association (AOA)
2. Liaise between Programs, Facilities, and System Administration when appropriate
3. Provide administrative oversight for resident issues requiring attention above Program Director level
4. Prepare an annual residency budget and manage its implementation
5. Provide an annual report to the governing body of Baptist Memorial Health Care

Designated Institutional Official (DIO)
Baptist Memorial Health Care has appointed the Chief Academic Officer to serve as the Designated Institutional Official (DIO). The DIO reports to the System Chief Academic Officer or System Chief Medical Officer.

The DIO’s responsibilities include the following:

1. Provide leadership and guidance for the sponsoring institution’s Graduate Medical Education Committee (GMEC) as the Chairman for this committee
2. Provide oversight and guidance to Program Directors for all submissions to the Accreditation Council for Graduate Medical Education (ACGME)
3. Provide oversight and administration of the Sponsoring Institution’s ACGME-accredited programs and ensure compliance with the ACGME Institutional, Common, and Specialty/Subspecialty-specific Program Requirements.
4. Review and edit or approve information that will be submitted to the ACGME
5. Review and edit or co-sign all program application forms as well as any correspondence or document submitted to the ACGME that addresses:
   a. Program citations
   b. Request for changes in the program that would have a significant impact, including financial on the program or institution
   c. Requests for duty hour exceptions for residents
6. Provide an annual written report on the current GME programs to the Baptist Board of Directors
7. Assist in the selection of qualified and attentive Program Directors for each residency program sponsored by Baptist Memorial Health Care
8. Work with the Program Directors to help maintain sound training programs for the residents and medical community
9. Provide guidance to the MEC for all GME related issues
10. Maintain the affiliate relationships with the Arkansas State University, New York Institute of Technology, the University of Mississippi Medical Center, the University of Tennessee Health Science Center, and Vanderbilt University Medical Center
11. Support the undergraduate and graduate medical curriculums in this community
12. Prepare an annual residency budget and manage its implementation

Program Director (PD)
Each Program Director (PD) of a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) will have the authority and accountability for the operation of the program. His/her length of service should be sufficient to maintain continuity of leadership and program stability. PD changes must be approved by the GMEC of the sponsoring institution.

Qualification of the Program Director will include:
1. Requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee
2. Current certification in the specialty by the American Board of Medical Specialties or specialty qualifications that are acceptable to the Review Committee
3. Current medical licensure and appropriate medical staff appointment

The Program Director’s responsibilities include the following:
1. Oversee and ensure the quality of didactic and clinical education in all sites that participate in the program
2. Approve a local director at each participating site who is accountable for resident education
3. Approve the selection of program faculty as appropriate
4. Evaluate program faculty
5. Approve the continued participation of program faculty based on evaluation
6. Monitor resident supervision at all participating sites
7. Prepare and submit all information required and requested by the ACGME
8. Ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution
9. Provide verification of residency education for all residents, including those who leave the program prior to completion
10. Implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, and to that end must:
   a. Distribute these policies and procedures to the residents and faculty
   b. Monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements
   c. Adjust schedules as necessary to mitigate excessive service demands and/or fatigue
   d. If applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue
11. Monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged
12. Comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents
13. Be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures
14. Obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting information or request to the ACGME
15. Obtain DIO review and co-signature on all program application forms, as well as any correspondence of document submitted to the ACGME that addresses
   a. Program citations
   b. Request for changes in the program that would have a significant impact, including financial, on the program or institution
16. Other requirements as indication by the program-specific requirements

**Associate Program Director (APD)**

Each Associate Program Director (APD) must fulfill the requirements as stated by the accrediting agency’s Program Requirements for the Specialty in which he/she serves. The APD must be attitudinally suited to conduct a training program.

The Associate Program Director’s responsibilities include the following:

1. Assist the Program Director to accomplish his/her responsibilities as stated in the accrediting agency’s Program Requirements
2. Fulfill his/her responsibilities as stated in the accrediting agency’s Program Requirements

**Faculty**

Faculty must make available non-clinical time to provide instruction to residents

**Program Coordinator**

Each Program must have a Program Coordinator to assist the Program Director, Associate Program Director, Faculty, and Residents with tasks associated with the Program. Program Coordinators may not be required to partake in non-Program related tasks at the expense of the Program. Programs may not share Program Coordinators except when Program Requirements allow.

**Other Affiliations**

GME coordinates the policies, rotations, and communications for learners and encompasses undergraduate, graduate, post-graduate levels and fellows. This ensures the quality and safety of the educational programs provided by the various Baptist facilities and overseen by the governing authorities of Baptist Memorial Health Care.
Resident Responsibilities and Supervision

Resident Duties

RESIDENT’S DUTIES

1. To develop a personal program of self-study and professional growth with guidance from the teaching staff.

2. To participate in safe, effective and compassionate patient care under physician supervision, commensurate with resident’s level of advancement and responsibility.

3. To participate in institutional activities to the extent required and to assume responsibility for teaching and supervising other residents and students.

4. To complete a minimum of one pre-approved research project and other Scholarly Activity as required by the Program and the Accreditation Council for Graduate Medical Education (ACGME) during the residency program.

5. To participate in Inter-professional Teams concerning Quality Improvement and Patient Safety activities as required by the Accreditation Council for Graduate Medical Education (ACGME)

6. To participate in institutional programs and activities to help identify system errors and implement potential systems solutions.

7. To adhere to established practices, policies and procedures of the Program and policies of all affiliated hospitals where required, including the timely completion of medical records.

8. To provide efficient, cost-effective and quality patient care.

9. To engage in the ethical practice of medicine in accordance with all applicable laws, rules and regulations and applicable standards of care.

10. To provide all medical services in a nondiscriminatory manner, without regard to a patient’s race, color, sex, age, religion, national origin, disability, or handicapping condition.

11. To cooperate with Baptist’s Quality Assurance, Total Quality Assessment, Patient Safety Organization, Risk Management, Human Resources and Compliance programs, including, if necessary, providing interviews, written statements, and participating in any investigation as requested by Baptist.
GME Trainee Work Environment

PURPOSE: To establish a policy that clarifies the established requirements of all Work Environments for Fellows, Residents, and Students participating in Graduate Medical Education Programs or Rotations at Baptist facilities.

POLICY: GME Trainee Work Environment Policy

PROCEDURE: In accordance with ACGME requirements, Baptist has established the following standards to ensure a safe and productive work environment for all GME Trainees.

- Each Program Director, with the assistance of his faculty, will be responsible for oversight and maintenance of the Work Environment for his/her program. Baptist Graduate Medical Education will be responsible for general oversight of all GME Trainees. The Chief Academic Officer and Graduate Medical Education department will maintain an “Open Door” policy for working with fellows, residents, students, facilities, and schools.
- Program and Baptist are committed to and responsible for promoting patient safety and resident well-being and to that end, will educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.
- Program and Baptist will ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
- Program and Baptist will ensure and monitor effective, structured hand-over processes by utilizing standardized Transitions of Care checklists and minimizing the number of transitions of patient care.
- In order to ensure a healthy and safe learning and working environment, Baptist will provide:
  - Access to food while on duty at all participating sites;
  - Safe, quiet, and private sleep/rest facilities available and accessible for residents/fellows;
  - Security and safety measures appropriate to the participating site,
  - Additional resources which may include Internet, electronic medical record access, access to library resources, a locked room or lockers for student personal items, and reasonable access to patients.
  - Biannual Resident Forums during which any resident/fellow employed by Baptist must have the opportunity to raise a concern to the forum. Resident Forums are conducted at least in part, under the guidance of the Chief Resident(s) and without the DIO, faculty members, or other administrators present.
Communication resources and technology: Faculty members and residents/fellows have ready access to adequate communication resources and technological support. Specifically, this will include:

- 24/7/365 IT Support
- 24/7/365 EMR Access and Support

Access to medical literature: Faculty members and GME Trainees have ready access to specialty/subspecialty-specific electronic medical literature databases and other current reference material in print or electronic format. This is provided with a combination of resources including the Baptist Medical Staff Library, online research capabilities, and Program-level libraries. Online Educational Resources includes UpToDate, PubMed, OPAC, OVID Nursing Online, etc.

Support Services and Systems: In order to ensure that the ACGME-accredited programs’ educational goals and objectives, and the residents’/fellows’ educational experience is not compromised by excessive reliance on residents/fellows to fulfill non-physician service obligations, Baptist will provide support services and systems which include:

- Peripheral intravenous access placement, phlebotomy, laboratory, pathology and radiology services and patient transportation services provided in a manner appropriate to and consistent with educational objectives and to support high quality and safe patient care; and,
- Electronic medical records are available at all participating sites to support high quality and safe patient care, residents’/fellows’ education, quality improvement and scholarly activities.

Baptist shall provide immediate emergency health care for Trainees if needed for illness or injury suffered during participation in the Program and for initial response to exposure to blood borne pathogens or other hazardous materials onsite. Rotating Trainees will then be referred to School for follow up at the earliest convenience provided such referral can be lawfully made under the Emergency Medical Treatment and Labor Act (EMT ALA) and/or any applicable similar state law.

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Baptist (for Programs sponsored by Baptist) or Baptist and School (for Programs sponsored by School) will monitor Trainees’ learning environment to identify positive and negative influences. Concerns regarding possible mistreatment of Trainees or failure of Trainees to abide by the highest standards of professionalism shall be addressed by Chief Academic Officer (Baptist residents/fellows) or reported to School (Rotating residents/fellows/students).

Baptist and School shall require its Faculty and Trainees providing services hereunder to refrain from conduct that may be reasonably considered offensive to others or disruptive to the workplace or patient care ("Inappropriate Conduct"). Examples of Inappropriate Conduct include, but are not limited to, the following:

- The use of threatening or abusive language directed at patients, patient families, visitors, colleagues, physicians, and any and all employees of Baptist;
- Making degrading or demeaning comments regarding patients, patient families, visitors, colleagues, physicians, and any and all employees of Baptist;
- The use of profanity or similarly offensive language while at Baptist and/or while speaking with or referring to patients, patient families, visitors, colleagues, physicians, and any and all employees of Baptist;
- Having physical contact with another individual that may be interpreted as threatening, intimidating or offensive;
- Making public derogatory comments or making similar entries in medical records about the quality of care being provided at Baptist or by Baptist's employees rather than directing such concerns through appropriate peer review or quality assurance channels; and
- Sexual harassment which, for purposes of this contract and not to the exclusion of any definition provided by law or Baptist's Medical Staff Bylaws, is defined as any unwelcome advance, request for sexual favors, or other verbal, written or physical conduct of a sexual nature that interferes with work performance or that creates an intimidating, offensive or hostile work environment.
PURPOSE: To establish a process and set guidelines for the purpose of standardization of supervision of Family Medicine residents under the oversight of the Graduate Medical Education department. “Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.” Common Program Requirements NAS, Introduction, Int.A.

POLICY: Family Medicine Program Supervision Policy

PROCEDURE: Supervision Standards for Family Medicine Resident Physicians in the Patient Care Settings

GENERAL REQUIREMENTS:
Resident Physicians are supervised by appropriately credentialed and privileged attending physicians. The program is responsible for maintaining a current accounting of procedural competencies and level of supervision required and for insuring that all supervising physicians comply with these guidelines.

DEFINITIONS:

Direct Supervision – The supervising physician is physically present with the resident/student and patient.

Indirect Supervision –

- **With direct supervision immediately available** – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- **With direct supervision available** – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/ or electronic modalities, and is available to provide Direct Supervision.

************ Please see attached grid for specific guidelines ************

Additional guidelines for residents:

**Progressive Authority and Responsibility**

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members:
The Clinical Competency Committee (CCC) and program director must evaluate each resident’s abilities according to ACGME Milestones.

Supervising faculty members will delegate patient care activities to residents based on the needs of the patient and the demonstrated abilities of the resident.

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

Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to them the appropriate level of patient care authority and responsibility.

There are circumstances in which all residents, regardless of level of training and experience, must verbally communicate with appropriate supervising faculty. These circumstances include:

- ICU admissions to the inpatient service
- Transfer of patients to a higher level of care, e.g. from the floor to the ICU, or critical change in a patient’s status, e.g. cardiac or respiratory arrest
- Change in DNR status
- Patient or family dissatisfaction
- Patient requesting AMA discharge
- Patient death

All residents are expected to progress during their residency period. Residents failing to demonstrate satisfactory progression will be subject to guidelines contained in the BMH GMEC policy for “Non-Renewal of Agreements.”

Responsibilities

General

- All patient care must be supervised by qualified faculty with appropriate credentials and privileges.
- PGY-1 level residents must be supervised either directly or indirectly, with direct supervision immediately available. If indirect supervision is provided, such supervision must be consistent with RRC policies. PGY-1 residents must meet established advancement criteria, with approval of the program director and faculty, in order to be eligible for indirect supervision.

Faculty Responsibilities

- Routinely review resident documentation in hospital and clinic medical records.
- Provide resident physicians with appropriate and constructive feedback.
- Serve as role models to residents, demonstrating professionalism and exemplary communication skills in patient care.
- Round daily on inpatients being cared for by residents or urgently, as dictated by circumstances or at the request of residents.
- Write or dictate daily notes on the above patients.
- Follow Medicare rules and regulations regarding documentation and billing.

Resident Responsibilities
• Residents are responsible for knowing the limits of their scope of authority and the circumstances under which they are permitted to act with conditional independence.
• Residents must write or dictate daily notes on patients under their care as appropriate. All orders must have dates and times.
• Residents must discuss patient care decisions with the attending physician as appropriate.
### SUPERVISION GUIDELINES

<table>
<thead>
<tr>
<th>Patient Setting / Clinical Activity</th>
<th>Initial Supervision Requirements: Supervision requirements for all entry-level resident physicians is identified below.</th>
<th>Advanced Supervision Requirements: These less stringent requirements will be awarded to each resident once the Clinical Competency Committee (CCC) has determined that the resident has achieved the appropriate competency level. This is usually obtained at the R-2 level.</th>
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<td>NON-ROUTINE, NON-BEDSIDE, NON-OR PROCEDURES (e.g., Cardiac Cath, Endoscopy, Interventional Radiology, etc.)</td>
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<td>EMERGENCY CARE - Immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted.</td>
<td>Indirect Supervision with Direct Supervision Available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.</td>
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<td>INPATIENT CARE / Hospital Discharge and Transfers</td>
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**PURPOSE:** To establish a policy for Resident Duty Hours that complies with the Accreditation Council for Graduate Medical Education (ACGME) and American Osteopathic Association (AOA) guidelines. To that end, the information below has been taken from both the ACGME and AOA Requirements.

**POLICY:** Duty Hours Policy

The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment. The learning objective of the program must not be compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents’ time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

**SUPERVISION:** See the GME Supervision Policy

**COMBINED ACGME/AOA-SPECIFIC REQUIREMENTS**:

**Maximum Hours per Week**
Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.

**Duty Hours Exceptions**
BMHCC does not permit exceptions to the Duty Hour policy.

**Moonlighting**
Residents must not be required to participate in moonlighting activities. Program Directors must evaluate each resident’s academic performance before granting permission for a resident to moonlight. Program Directors must continue to monitor each resident’s academic and clinical performance when moonlighting is served. If at any time, the Program Director believes that the resident should not participate in moonlighting activities because of declining academic or clinical performance, permission to participate in moonlighting may be withdrawn.

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

PGY-1 residents are not permitted to moonlight.
See the GME Moonlighting policy for additional guidance.

**Mandatory Time Free of Duty**
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

**Maximum Duty Period Length**
Duty periods of PGY-1 residents must not exceed 16 hours in duration. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. All Duty Hour instances in excess of twenty-four (24) hours must be reported by the resident/fellow in writing with rationale to the DME/Program Director and reviewed by the GMEC for monitoring individual residents and Programs.

Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must: appropriately hand over the care of all other patients to the team responsible for their continuing care; and, document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

**Minimum Time Off between Scheduled Duty Periods**
- PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
- Intermediate-level residents [as defined by the Review Committee] should have ten hours free of duty, and must have eight hours between scheduled duty periods. They must have at least fourteen hours free of duty after twenty-four hours of in-house duty.
- Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.
- Following a shift of twenty to twenty-four (20-24) hours, all residents must have at least fourteen (14) hours off before being required to be on duty or on call again.
- Following a shift of greater than twelve (12) but less than twenty (20) hours, residents must have at least ten (10) hours off before being required to be on duty or on call again.
• All residents shall have forty-eight (48) hours off on alternate weeks, or at least one twenty-four (24) hour period off each week and shall have no call responsibility during that time. At-home call cannot be assigned on these days.
• All off-duty time must be totally free from clinical or assigned classroom educational activity.

Emergency Department Duty
Residents assigned to Emergency Department duty shall work no longer than twelve (12) hour shifts with no more than thirty (30) additional minutes allowed for transfer of care. In the event that any resident works more than twelve and one-half (12 ½) hours, he/she shall be required to submit documentation to the DME/Program Director an explanation for the excessive time. Such documentation shall be reviewed the GMEC for monitoring of individual residents and Programs.

Interruption of Patient Care
Each Program shall include provisions for continuity of patient care in the event that a resident has met or exceeded his/her duty hour limits. Such provisions may include reassignment of patient care to faculty or appropriate additional residents. Patient care responsibility is not precluded by this duty hours policy.

Maximum Frequency of In-House Night Float
Residents must not be scheduled for more than six consecutive nights of night float.

Maximum In-House On-Call Frequency
PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

At-Home Call
Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

* From ACGME Common Program Requirements NAS 2015 and AOA Res. No. B-8 – M/2015
PURPOSE: To establish a policy for resident moonlighting that complies with the Accreditation Council for Graduate Medical Education (ACGME) and American Osteopathic Association (AOA) guidelines. This policy should be considered to be in addition to the GME Duty Hour Policy and the Baptist Secondary Employment Policy.

POLICY: Resident Moonlighting Policy

PROCEDURE: External Moonlighting is defined as voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites. External Moonlighting must be considered part of the eighty (80) hour weekly limit on duty hours.

Internal Moonlighting is defined as voluntary, compensated, medically-related work (not related with training requirements) performed within the institution in which the resident is in training or at any of its related participating sites. Residents will not be required to participate in Internal Moonlighting activities. Internal Moonlighting must be considered part of the eighty (80) hour weekly limit on duty hours.

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. PGY-1 residents are not permitted to moonlight.

Programs will monitor resident duty hours, including moonlighting, with a frequency sufficient to ensure compliance with ACGME requirements. If necessary, the program will adjust schedules to mitigate excessive service demands. At no time will residents be permitted to work more than eighty (80) hours per week inclusive of scheduled residency hours, external and internal moonlighting. All residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

To that end and to ensure that professional activities outside the program do not interfere with a resident's performance, the program director must review and at his / her discretion, issue written approval for all extramural professional activities. Residents are required to complete a duty hour log and submit these to the Residency Coordinator biweekly. Programs will submit a summative moonlighting report to the GMEC on a semiannual basis.

Practice activities permitted outside the educational program vary with the academic performance level of each resident.
Each resident is responsible for attaining and maintaining the appropriate state medical license where moonlighting occurs. In addition, each resident is responsible for attaining and maintaining the appropriate separate liability insurance. The Baptist liability trust does not cover residents during external moonlighting activities.

Violation of this moonlighting policy could result in disciplinary actions up to and including dismissal from the Baptist Memorial Hospital Residency Program.
I, ______________________________________________, Program Director of the Program, do hereby acknowledge that ________________________________________, is engaging in extracurricular moonlighting activities at ______________________________________________________________. This resident has reviewed and agrees to abide by the Resident Duty Hours Policy. Resident has been advised to limit his moonlighting to ________ hours / week. Further, the resident is required to submit monthly a duty log for all moonlighting hours worked. It is also stipulated that moonlighting activity is not covered under the Baptist Memorial Hospital Malpractice Liability Insurance Policy.

Program Director

Date

Resident

Date
General Competency-Based Curricular Expectations of all Residents:

DOCUMENTATION OF RESIDENT PERFORMANCE AND ATTAINMENT OF ACGME COMPETENCIES FOR GRADUATION

Documentation of resident performance consists of, but is not limited to, all evaluations returned from all rotations and preceptors, copies of licensure and permits, letters of communication, test scores, Resident-Director evaluations, any corrective action plans and copies of experience documentation. These records are all part of the resident’s permanent file. The permanent files are kept in the Office of Graduate Medical Education and are considered confidential. Appropriate release of information is required for review or copying of any contents by anyone other than the Program Director, residency faculty or the resident.

To successfully graduate at the end of 36 months from our Family Medicine Residency, the resident must complete the required curriculum and become competent, as outlined in EDUCATION GOALS and below, in the six domains of ACGME Competencies.

Please note:
- PGY-2 is expected to attain PGY-1 & PGY-2 learning objectives
- PGY-3 should attain all learning objectives

Patient Care / General Objectives
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

<table>
<thead>
<tr>
<th>PG1 Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform a thorough history and physical examination</td>
<td>mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log</td>
<td>Meet expected competency level on rotation evals / Milestones</td>
</tr>
<tr>
<td>2. Synthesize data into a problem list and differential diagnosis</td>
<td>mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log</td>
<td>Meet expected competency level on rotation evals / Milestones</td>
</tr>
<tr>
<td>3. Formulate a diagnostic and therapeutic plan with some supervision</td>
<td>mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log</td>
<td>Meet expected competency level on rotation evals / Milestones</td>
</tr>
<tr>
<td>Objective</td>
<td>Measurement Tool</td>
<td>Expected Outcome</td>
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</tr>
<tr>
<td>4. Demonstrate humanistic and professional behavior in patient interactions</td>
<td>mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log</td>
<td>Meet expected competency level on rotation evals / Milestones</td>
</tr>
<tr>
<td>5. Applies preventive care in an outpatient setting</td>
<td>mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log</td>
<td>Meet expected competency level on rotation evals / Milestones</td>
</tr>
<tr>
<td>6. Provide effective preventive health care and health care risk factor reduction to patients and their families</td>
<td>Direct observation, rotation eval / Milestones, chart review</td>
<td>Meet expected competency level on rotation evals / Milestones</td>
</tr>
</tbody>
</table>

### PG2

**Objective**

1. Coordinate patient care among all members of the health care team
2. Formulate therapeutic and diagnostic plan independently
3. Use information technology to support patient care decisions
4. Counsels and educates patients and families
5. Develop and carry out patient care plans, using principles of evidence-based decision-making, appropriate prioritization, and taking into account the needs, beliefs, and resources of patient and family

**Measurement Tool**

- monthly global rating forms, patient and peer surveys, procedure logs

**Expected Outcome**

- Meet expected competency level on rotation evals / Milestones
- Meet institutional benchmarks on patient evals

### PG3

**Objective**

1. Efficiently evaluate and manage patients in the inpatient and outpatient setting at the level of a family physician

**Measurement Tool**

- monthly global rating forms, patient/peer/nurse surveys, procedure logs

**Expected Outcome**

- Meet expected competency level for training on Rotation evals / Milestones
<table>
<thead>
<tr>
<th></th>
<th>Function competently as a family medicine consultant</th>
<th>monthly global rating forms, patient/peer/nurse surveys, procedure logs</th>
<th>Meet expected competency level for training on Rotation evals / Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Function competently as a family medicine consultant</td>
<td>monthly global rating forms, patient/peer/nurse surveys, procedure logs</td>
<td>Meet expected competency level for training on Rotation evals / Milestones</td>
</tr>
<tr>
<td>3.</td>
<td>Gather essential and accurate information using the following clinical skills: medical interviewing, physical examination, diagnostic studies, and developmental assessments</td>
<td>Direct observation, rotation evaluations / Milestones</td>
<td>Meet expected competency level for training on Rotation evals / Milestones</td>
</tr>
<tr>
<td>4.</td>
<td>Make informed diagnostic and therapeutic decisions based on patient information, current scientific evidence and clinical judgment, using clinical problem-solving skills, recognizing the limits of one’s knowledge and expertise, gathering appropriate information and using colleagues and consultants appropriately</td>
<td>Direct observation, rotation evaluations / Milestones</td>
<td>Meet expected competency level for training on Rotation evals / Milestones</td>
</tr>
<tr>
<td>5.</td>
<td>Effectively use common therapies within the scope of medical knowledge goals for a Family Physician in the various curriculum domains (see specific rotation Medical knowledge goals), including a variety of prescription and non-prescription medications, intravenous fluids, as well as special diets and nutritional supplements. Be familiar with therapies commonly used by sub-specialists and other professionals who care for patients with specialty specific diseases.</td>
<td>Direct observation, rotations evaluations / Milestones</td>
<td>Meet expected competency level on rotation evaluations / Milestones</td>
</tr>
<tr>
<td>6.</td>
<td>Counsel patients and families in a supportive manner so they can understand their illness or injury and its treatment, share in decision-making, make informed consent and</td>
<td>Direct observation, rotation evaluations / Milestones, patient satisfaction surveys</td>
<td>Meet expected competency level on rotation evaluations / Milestones and meet institutional benchmarks on patient satisfaction surveys</td>
</tr>
</tbody>
</table>
participate actively in the
care plan

<table>
<thead>
<tr>
<th>Objective</th>
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<tbody>
<tr>
<td>7. End of Life Care. Planning for end of life decision. Counseling patients and their families in regards to DPOA, Hospice, and Comfort Care measures in a thoughtful and respectful manner</td>
<td>Direct observation, patient survey, rotation eval / Milestones</td>
<td>Meet expected competency level on rotation evals / Milestones and meet institutional benchmarks on patient sat. surveys</td>
</tr>
</tbody>
</table>

Patient Care / Procedural Objectives

**PG1**

<table>
<thead>
<tr>
<th>Objective</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Perform the majority of procedures required by rotation specific curriculum</td>
<td>Direct observation, rotation evals, procedure evals</td>
<td>Attain competency level 2 - Able to perform this procedure with direct supervision and assistance</td>
</tr>
</tbody>
</table>

**PG2**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform and supervise procedures required by rotation specific curriculum</td>
<td>Direct observation, rotation evals, procedure evals</td>
<td>Attain competency level 3 - Able to perform this procedure without direct supervision</td>
</tr>
</tbody>
</table>

**PG3**

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<tr>
<th>Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform and supervise every procedure required by rotation specific curriculum</td>
<td>Direct observation, rotation evals, procedure evals</td>
<td>Attain competency level 4 - Demonstrates a high level of technical skill and understanding of this procedure</td>
</tr>
</tbody>
</table>

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents are expected to:

**Expected outcome for MEDICAL KNOWLEDGE:**

Attain competence in Medical Knowledge goals below and specific to each curricular rotation/longitudinal experience.

Meet expected competency level on rotations and attaining >30% when compared to national peers for PGY on annual In-service Training Exam (ITE), improving on personal score each year, and passing the ABFM certification exam at the end of the PGY 3.

**PG1**

<table>
<thead>
<tr>
<th>Objective</th>
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</thead>
</table>
1. Describe basic pathophysiology for common family medicine conditions | in-service examination, monthly global rating forms, conference attendance log | Meet expectation competency level on rotation evals / Milestones: ITE exam

2. Develop basic knowledge base for common inpatient and outpatient conditions | in-service examination, monthly global rating forms, conference attendance log | Meet expectation competency level on rotation evals / Milestones: ITE exam

**PG2**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate in-depth pathophysiology for common family medicine conditions</td>
<td>In-service examination, monthly global rating forms, conference attendance log</td>
<td>Meet expectation competency level on rotation evals / Milestones: ITE exam</td>
</tr>
<tr>
<td>2. Develop knowledge of medical literature analysis</td>
<td>In-service examination, monthly global rating forms, conference attendance log</td>
<td>Meet expectation competency level on rotation evals / Milestones: ITE exam</td>
</tr>
</tbody>
</table>

**PG3**

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</thead>
<tbody>
<tr>
<td>1. Demonstrate in-depth pathophysiology for commonly and uncommonly seen family medicine conditions</td>
<td>in-service examination, monthly global rating forms, conference attendance log</td>
<td>Meet expectation competency level on rotation evals / Milestones: ITE exam</td>
</tr>
<tr>
<td>2. Apply critical reading skills to current family medicine literature</td>
<td>in-service examination, monthly global rating forms, conference attendance log</td>
<td>Meet expectation competency level on rotation evals / Milestones: ITE exam</td>
</tr>
<tr>
<td>3. Develop a systematic approach to acquiring and maintaining current medical knowledge</td>
<td>in-service examination, monthly global rating forms, conference attendance log</td>
<td>Meet expectation competency level on rotation evals / Milestones: ITE exam</td>
</tr>
<tr>
<td>4. Critically evaluate current medical information and scientific evidence and modify one’s knowledge base accordingly</td>
<td>Direct observation, conferences and journal reporting, Milestones</td>
<td>Satisfactory rotation evals, participate in and lead conferences, Milestones</td>
</tr>
<tr>
<td>5. Recognize the limits of one’s knowledge and expertise by seeking information needed to answer clinical questions and using consultants and referrals appropriately, Use this process to guide lifelong learning plans</td>
<td>Direct observation, rotation evals, Milestones, peer eval</td>
<td>Meet expected competency level on rotation evals / Milestones</td>
</tr>
<tr>
<td>6. Apply current medical information and scientific evidence effectively to</td>
<td>Direct observation, rotation evals / Milestones, peer evals</td>
<td>Meet expected competency level on evals / Milestones</td>
</tr>
</tbody>
</table>
patient care (e.g. use an open-minded, analytical approach demonstrating sound clinical judgment and appropriate attention to priorities).

Practice-based Learning and Improvement
Residents must demonstrate the ability to investigate and self-evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

1. Identify strengths, deficiencies, and limits in one’s knowledge and expertise.
2. Set learning and improvement goals.
3. Identify and perform appropriate learning activities.
4. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.
5. Incorporate formative evaluation feedback into daily practice.
6. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems.
7. Use information technology to optimize learning.
8. Participate in the education of patients, families, students, residents and other health professionals.

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<tr>
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<tbody>
<tr>
<td>1. Ask for help when needed</td>
<td>Peer evals, PBLI project, Faculty eval / Milestones</td>
<td>Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones</td>
</tr>
<tr>
<td>2. Seek and accept feedback</td>
<td>Peer evals, PBLI project, Faculty eval / Milestones</td>
<td>Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones</td>
</tr>
<tr>
<td>3. Participate in quality improvement activities</td>
<td>Peer evals, PBLI project, Faculty eval / Milestones</td>
<td>Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones</td>
</tr>
<tr>
<td>4. Demonstrate improvement in clinical management</td>
<td>Peer evals, PBLI project, Faculty eval / Milestones</td>
<td>Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones</td>
</tr>
<tr>
<td>5. Teach M3 students effectively</td>
<td>Peer evals, PBLI project, Faculty eval / Milestones</td>
<td>Meet expected competency level on faculty and peer evals / Milestones</td>
</tr>
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6. Demonstrate ability to access medically accurate web-based resources

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<tr>
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<tbody>
<tr>
<td>1. Teach interns and M4 students effectively</td>
<td>monthly global rating forms, peer evaluations, student evaluations</td>
<td>Meet expected competency level on faculty and peer evals / Milestones</td>
</tr>
<tr>
<td>2. Use patient care errors and near-misses to teach others</td>
<td>monthly global rating forms, peer evaluations, student evaluations</td>
<td>Meet expected competency level on faculty and peer evals / Milestones</td>
</tr>
<tr>
<td>3. Use information technology such as PubMed or Ovid to enhance patient care</td>
<td>monthly global rating forms, peer evaluations, student evaluations</td>
<td>Meet expected competency level on faculty and peer evals / Milestones</td>
</tr>
<tr>
<td>4. Systematically assess the health care needs of one’s practice population and use this information to direct population-based problem solving with special attention to preventable morbidity and risk</td>
<td>Population management projects in clinic, PBLI annual project</td>
<td>Meet goals or improve performance to meet benchmarks for chronic disease</td>
</tr>
<tr>
<td>5. Seek and incorporate feedback and self-assessment into a plan for professional growth and practice improvement (e.g. use evaluation provided by patients, peers, superiors, and subordinates to improve patient care).</td>
<td>Mentor sessions, sign off all evals</td>
<td>Competency for level of training noted on Mentor/ Mentee summary sheets; satisfactory performance noted on evals / Milestones</td>
</tr>
</tbody>
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**PG3**

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<thead>
<tr>
<th>Objective</th>
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<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Teach interns, students, and other residents effectively</td>
<td>Faculty evals / Milestones, Peer evals</td>
<td>Meet expected competency level on faculty and peer evals / Milestones</td>
</tr>
<tr>
<td>2. Analyze own practice for needed improvement</td>
<td>monthly global rating forms, peer evaluations</td>
<td>Meet expected competency level on faculty and peer evals / Milestones</td>
</tr>
<tr>
<td>3. Complete a QA/QI project under faculty direction</td>
<td>monthly global rating forms, peer evaluations</td>
<td>Meet expected competency level on faculty and peer evals / Milestones</td>
</tr>
<tr>
<td>4. Use scientific methods and evidence to investigate, evaluate, and improve one’s own patient care practice;</td>
<td>Peer evals, PBLI project, Faculty eval / Milestones</td>
<td>Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones</td>
</tr>
</tbody>
</table>
continually strive to integrate best evidence into daily practice

| 5. Demonstrate willingness and capability to be a life-long learner by pursuing answers to clinical questions, using literature, texts, information technology, patients, colleagues, and formal teaching conferences. | Attendance at Block Didactic Days; feedback on rotation evals from faculty | 100% attendance required unless excused by PD, Satisfactory performance on Eval/Milestones: meet expected competency level |

| 6. Be prepared to alter one’s practice of medicine over time in response to new discoveries and advances in epidemiology and clinical care | 360° evals, Chronic disease management data | Satisfactory performance on all evals/Milestones; meet competency for level of training, meet goals or improve performance to meet benchmarks for chronic disease management for level of training |

Interpersonal and Communication Skills
Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, patients’ families, and health professionals. Residents are expected to:

1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.
2. Communicate effectively with physicians, other health professionals, and health-related agencies.
3. Work effectively as a member or leader of a health care team or other professional group.
4. Act in a consultative role to other physicians and health professionals.
5. Maintain comprehensive, timely, and legible medical records, as applicable.

PG1
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<tbody>
<tr>
<td>1. Present a case accurately and succinctly</td>
<td>Monthly global rating forms (with chart audits), mini-CEXes, 360 degree evaluations including patient and student surveys</td>
<td>Satisfactory Performance on all evals/Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>2. Provide timely, legible, thorough, succinct medical record documentation - histories and physical examinations, progress notes, and discharge summaries</td>
<td>Monthly global rating forms (with chart audits), mini-CEXes, 360 degree evaluations including patient and student surveys</td>
<td>Satisfactory Performance on all evals/Milestones: meet competency for level of training</td>
</tr>
<tr>
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</tr>
<tr>
<td>3. Work well within team context relating to students, attendings, other resident staff, nurses, and patients</td>
<td>monthly global rating forms (with chart audits), mini-CEXes, 360 degree evaluations including patient and student surveys</td>
<td>Satisfactory Performance on all evals/ Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>4. Communicate and establish a therapeutic relationship with patients</td>
<td>monthly global rating forms (with chart audits), mini-CEXes, 360 degree evaluations including patient and student surveys</td>
<td>Satisfactory Performance on all evals/ Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>5. Communicates effectively with peers and health care team in a way that enhances patient safety and work place satisfaction. Communicates with health care team in a professional and respectful way.</td>
<td>Peer Evals, 360° Evaluations</td>
<td>Satisfactory Performance on all evals/ Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>6. Maintain comprehensive, timely, and legible medical records</td>
<td>Medical records/ transcription, delinquency reporting; chart review</td>
<td>Charts completed within 24 hours, no more than two delinquent notices per year from inpatients. medical records</td>
</tr>
<tr>
<td>7. Develop communication skills required to direct ACLS/PALS,NRP codes</td>
<td>Direct observation, nursing evals, preceptor evals</td>
<td>Satisfactory performance on all evals/ Milestones: meet expected competency level; successful completion of ACLS/PALS/NRP courses</td>
</tr>
</tbody>
</table>

**PG2**

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<tr>
<th>Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provide timely, legible, thorough and succinct resident admit and progress notes</td>
<td>monthly global rating forms (with chart audits), 360 degree evaluations including patient, peer, nurse and student surveys</td>
<td>Satisfactory Performance on all evals/ Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>2. Work effectively as a leader of the health care team</td>
<td>monthly global rating forms (with chart audits), 360 degree evaluations including patient, peer, nurse and student surveys</td>
<td>Satisfactory Performance on all evals/ Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>3. Provide education and counseling to patients, families, and colleagues</td>
<td>monthly global rating forms (with chart audits), 360 degree evaluations including patient, peer, nurse and student surveys</td>
<td>Satisfactory Performance on all evals/ Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>4. Demonstrate skill in delivering end-of-life counseling to patients</td>
<td>monthly global rating forms (with chart audits), 360 degree evaluations including patient, peer, nurse and student surveys</td>
<td>Satisfactory Performance on all evals/ Milestones: meet competency for level of training</td>
</tr>
</tbody>
</table>

**PG3**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
</table>

98
1. Work effectively as a leader of the health care team including a team with potential dysfunction

   - monthly global rating forms, 360 degree evaluations
   - Satisfactory Performance on all evals/ Milestones: meet competency for level of training

2. Demonstrate skill in handling all difficult patient care situations

   - monthly global rating forms, 360 degree evaluations
   - Satisfactory Performance on all evals/ Milestones: meet competency for level of training

3. Function effectively as a consultant for specialty and subspecialty care

   - monthly global rating forms, 360 degree evaluations
   - Satisfactory Performance on all evals/ Milestones: meet competency for level of training

4. Communicate effectively in a developmentally appropriate manner with patients and families to create and sustain a therapeutic relationship across the broad range of socioeconomic and cultural backgrounds.

   - Patient Satisfaction Surveys, Video recording / review with Mentor, Direct Observation, Rotation Eval / ACGME Milestones, Nursing Eval
   - Satisfactory Performance on all evals/ Meeting competency for level of training, Video Review to demonstrate competency in counseling/ decision making for level of training / Milestones

5. Develop effective approaches for teaching students, colleagues, other professionals, and lay groups
   a. Work effectively as a leader of the health care team including a team with potential dysfunction
   b. Demonstrate skill in handling all difficult patient care situations
   c. Function effectively as a consultant for specialty and subspecialty care

   - 360° evals
   - Satisfactory performance on all evals/ Milestones, meet competency for level of training

---

**Professionalism**

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

1. Compassion, integrity, and respect for others.
2. Responsiveness to patient needs that supersedes self-interest.
3. Respect for patient privacy and autonomy.
4. Accountability to patients, society and the profession.
5. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish trust with patients and staff</td>
<td>monthly global rating forms, 360 degree evaluations, mini-CEXes</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>2. Demonstrate respect, compassion, and integrity</td>
<td>monthly global rating forms, 360 degree evaluations, mini-CEXes</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>3. Demonstrate punctuality, reliability, and honesty</td>
<td>monthly global rating forms, 360 degree evaluations, mini-CEXes</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>4. Show regard for the opinions of others</td>
<td>monthly global rating forms, 360 degree evaluations, mini-CEXes</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>5. Maintain patient confidentiality</td>
<td>monthly global rating forms, 360 degree evaluations, mini-CEXes</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>6. Compassionately respond to issues of culture, age, gender, ethnicity, and disability in patient care</td>
<td>monthly global rating forms, 360 degree evaluations, mini-CEXes</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>7. Demonstrate commitment, responsibility, accountability for patient care, including continuity of care.</td>
<td>360° Evals</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>8. Maintain honesty and integrity in one’s professional duties.</td>
<td>360° Evals</td>
<td>Satisfactory performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>9. Consistently use compassion and empathy in one’s role as a physician.</td>
<td>Patient Evals, Peer Evals, Faculty Evals, Rotation Evals</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>10. Maintain professional boundaries in one’s dealings with patients, family, staff, and professional colleagues</td>
<td>Patient Evals, Faculty Evals, Rotation Evals</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>11. Develop and demonstrate an altruistic attitude / Place the needs of patients and society over one’s own self-interest</td>
<td>Rotation Evals, Peer Evals</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>12. Demonstrate sensitivity and responsiveness to patients’ and colleagues’ gender, age, culture, disabilities</td>
<td>Video Taping / review with Mentor, Chart Review, Rotation Evals / Milestones, Direct Observation</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
</tbody>
</table>
Meet high standards of legal and ethical behavior.

Satisfactory Performance on all evals/ Milestones: meeting competency for level of training

Develop a healthy lifestyle, fostering behaviors that help balance personal goals and professional responsibilities. Recognize and respond to personal stress and fatigue that might interfere with professional duties.

Sign and complete mentor Session documentation semiannually. Sign Curricular Planning Documents annually. Successfully complete post-test following sleep deprivation lectures annually.

### PG2

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<thead>
<tr>
<th>Objective</th>
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</thead>
<tbody>
<tr>
<td>1. Display initiative and leadership</td>
<td>monthly global rating forms, 360 degree evaluations</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>2. Delegate responsibility to others effectively</td>
<td>monthly global rating forms, 360 degree evaluations</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>3. Acknowledge errors and work to minimize them</td>
<td>monthly global rating forms, 360 degree evaluations</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
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### PG3

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<tr>
<th>Objective</th>
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<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrates concern for educational development of students and residents</td>
<td>monthly global rating forms, 360 degree evaluations</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>2. Volunteers for activities for the good of the institution and community</td>
<td>monthly global rating forms, 360 degree evaluations</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
<tr>
<td>3. Demonstrates understanding of the ethical concerns about pharmaceutical and patient gifts</td>
<td>monthly global rating forms, 360 degree evaluations</td>
<td>Satisfactory Performance on all evals/ Milestones: meeting competency for level of training</td>
</tr>
</tbody>
</table>

### Systems-based Practice

Residents must demonstrate an awareness of, and responsiveness to, the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:
1. Work effectively in various health care delivery settings and systems relevant to their clinical specialty.
2. Coordinate patient care within the health care system relevant to their clinical specialty.
3. Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate.
4. Advocate for quality patient care and optimal patient care systems.
5. Work in inter-professional teams to enhance patient safety and improve patient care quality.
6. Participate in identifying system errors and implementing potential systems solutions.

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<tbody>
<tr>
<td>1. Demonstrate ability to practice medicine in a private, government, and municipal hospital setting</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys</td>
<td>Satisfactory performance on all evals / attain institutional quality goals</td>
</tr>
<tr>
<td>2. Demonstrate ability to practice medicine in an ambulatory clinic</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys</td>
<td>Satisfactory performance on all evals / attain institutional quality goals</td>
</tr>
<tr>
<td>3. Function as a physician within a team</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys</td>
<td>Satisfactory performance on all evals / attain institutional quality goals</td>
</tr>
<tr>
<td>4. Serve as a patient advocate in the outpatient and inpatient setting</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys</td>
<td>Satisfactory performance on all evals / attain institutional quality goals</td>
</tr>
<tr>
<td>5. Work with ancillary team members (discharge planners, case managers, social workers) to provide high quality, cost-effective care</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys</td>
<td>Satisfactory performance on all evals / attain institutional quality goals</td>
</tr>
<tr>
<td>6. Advocate for the promotion of health and the prevention of disease and injury in populations.</td>
<td>Quality performance reports, HEDIS reports</td>
<td>Satisfactory performance on all evals / attain institutional quality goals</td>
</tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Direct care in inpatient and outpatient settings as a member of a multidisciplinary team</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys</td>
<td>Satisfactory Performance on all evals/Milestones: meet competencies for level of training</td>
</tr>
<tr>
<td>2. Use systematic approaches to reduce errors</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys</td>
<td>Satisfactory Performance on all evals/Milestones: meet competencies for level of training</td>
</tr>
</tbody>
</table>
3. Use scientific methods and evidence to investigate, evaluate and improve one’s own patient care practice; continually strive to integrate best evidence into daily practice.

QI/QA Projects, Presentation/ Evals

Satisfactory Performance on all evals/Milestones: meet competencies for level of training

4. Practice cost-effective health care and resource allocation that does not compromise quality of care.

Quality measurement standards

Evaluate based on institution and/or community quality standards

5. Work with health care managers and providers to assess, coordinate, and improve patient care, consistently advocating for high quality

360° Evals / ACGME Milestones

Satisfactory Performance on all evals / Milestones: meet competency for level of training

6. Acknowledge medical errors and develop practice systems to prevent them

Direct Observation, Chart Review, 360° Evals, Peer Review Data

Complete Resident Peer Review as needed. Report retained in resident portfolio to include statement from resident and plan for improvement/lessons learned. Chart review notes placed in portfolio and reviewed at mentor sessions.

Satisfactory Performance on all evals/Milestones: meet competency for level of training

PG3

<table>
<thead>
<tr>
<th>Objective</th>
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<tbody>
<tr>
<td>1. Demonstrate knowledge of types of medical practice and health delivery systems</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys, portfolio (QA/QI project)</td>
<td>Satisfactory Performance on all evals / Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>2. Practice effective allocation of health care resources to avoid compromising quality of care</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys, portfolio (QA/QI project)</td>
<td>Satisfactory Performance on all evals / Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>3. Demonstrate knowledge of business aspects of medical practice including coding and insurance</td>
<td>monthly global rating forms, 360 degree evaluations, patient surveys, portfolio (QA/QI project)</td>
<td>Satisfactory Performance on all evals / Milestones: meet competency for level of training</td>
</tr>
<tr>
<td>4. Advocate for patients in one’s practice, by helping them with systems complexities and identifying resources to meet their needs.</td>
<td>360° Evals / ACGME Milestones</td>
<td>Satisfactory Performance on all evals / Milestones: meet competency for level of training</td>
</tr>
</tbody>
</table>
MILESTONE EVALUATION EXPECTED OUTCOMES:

Specific Rotation Evaluations will be based on the above competency goals and include the rotation specific Patient Care and Medical Knowledge Goals. Evaluation will be on a 5-point Likert scale that will correlate with the ACGME Worksheets from the Family Medicine Milestone Project; recorded in New Innovations (web-based Evaluation/Duty-Hour Recording data system). Rotation specific evaluations will be reviewed semi-annually by the Clinical Competency Committee, with the resident given a summative evaluation of competency skills.

Referencing the ACGME Family Medicine Milestone Project summative evaluation below, note expected minimal levels of competency in all domains will be as follows:

- PGY1 at entry: Level 1 or greater
- PGY 1 to 2: Level 2 or greater
- PGY 2 to 3: Level 3 or greater
- PGY1 at 6 months: Level 1.5 or greater
- PGY 2 at 6 months: Level 2.5 or greater
- PGY 3 at 6 months: Level 3.5

Minimal requirement to matriculate to independent practice at graduation: Level 4
PATIENT CARE

Family physicians provide accessible, quality, comprehensive, compassionate, continuous, and coordinated care to patients in the context of family and community, not limited by age, gender, disease process, or clinical setting, and by using the biopsychosocial perspective and patient-centered model of care.

PC-1 Cares for acutely ill or injured patients in urgent and emergent situations and in all settings

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
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</thead>
<tbody>
<tr>
<td>Gathers essential information about the patient (history, exam, diagnostic testing, psychosocial context)</td>
<td>Consistently recognizes common situations that require urgent or emergent medical care</td>
<td>Consistently recognizes complex situations requiring urgent or emergent medical care</td>
<td>Appropriately prioritizes the response to the acutely ill patient</td>
<td>Provides and coordinates care for acutely ill patients within local and regional systems of care</td>
</tr>
<tr>
<td>Generates differential diagnoses</td>
<td>Stabilizes the acutely ill patient utilizing appropriate clinical protocols and guidelines</td>
<td>Appropriately prioritizes the response to the acutely ill patient</td>
<td>Demonstrates awareness of personal limitations regarding procedures, knowledge, and experience in the care of acutely ill patients</td>
<td></td>
</tr>
<tr>
<td>Recognizes role of clinical protocols and guidelines in acute situations</td>
<td>Generates appropriate differential diagnoses for any presenting complaint</td>
<td>Develops appropriate diagnostic and therapeutic management plans for less common acute conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generates appropriate differential diagnoses for any presenting complaint</td>
<td>Develops appropriate diagnostic and therapeutic management plans for acute conditions</td>
<td>Addresses the psychosocial implications of acute illness on patients and families</td>
<td></td>
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</tr>
<tr>
<td>Develops appropriate diagnostic and therapeutic management plans for acute conditions</td>
<td>Arranges appropriate transitions of care</td>
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PC-2 Cares for patients with chronic conditions

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<thead>
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</table>
Recognizes chronic conditions

Accurately documents a clinical encounter on a patient with a chronic condition, and generates a problem list.

Recognizes that chronic conditions have a social impact on individual patients.

Establishes a relationship with the patient as his or her personal physician.

Collects, organizes and reviews relevant clinical information.

Recognizes variability and natural progression of chronic conditions and adapts care accordingly.

Develops a management plan that includes appropriate clinical guidelines.

Uses quality markers to evaluate the care of patients with chronic conditions.

Understands the role of registries in managing patient and population health.

Consistently applies appropriate clinical guidelines to the treatment plan of the patient with chronic conditions.

Engages the patient in the self-management of his or her chronic condition.

Clarifies the goals of care for the patient across the course of the chronic condition and for his or her family and community.

Consistently applies appropriate clinical guidelines to the treatment plan of the patient with chronic conditions.

Engages the patient in the self-management of his or her chronic condition.

Clarifies the goals of care for the patient across the course of the chronic condition and for his or her family and community.

Begins to manage the conflicting needs of patients with multiple chronic conditions or multiple co-morbidities.

Leads care teams to consistently and appropriately manage patients with chronic conditions and co-morbidities.

Facilitates patients’ and families’ efforts at self-management of their chronic conditions, including use of community resources and services.

Personalizes the care of complex patients with multiple chronic conditions and co-morbidities to help meet the patients’ goals of care.

Continually uses experience with patients and evidence-based medicine in population management of chronic condition patients.

PC-3 Partners with the patient, family, and community to improve health through disease prevention and health promotion

Level 1 Collects family, social, and behavioral history

Demonstrates awareness of recommendations for health maintenance and screening guidelines developed by various organizations

Level 2 Identifies the roles of behavior, social determinants of health, and genetics as factors in health promotion and disease prevention

Incorporates disease prevention and health promotion into practice

Reconciles recommendations for health maintenance and screening guidelines developed by various organizations

Level 3 Explains the basis of health promotion and disease prevention recommendations to patients with the goal of shared decision making

Describes risks, benefits, costs, and alternatives related to health promotion and disease prevention activities

Partners with the patient and family to overcome barriers to

Level 4 Tracks and monitors disease prevention and health promotion for the practice population

Integrates disease prevention and health promotion seamlessly in the ongoing care of all patients

Level 5 Integrates practice and community data to improve population health

Partners with the community to improve population health
disease prevention and health promotion

Mobilizes team members and links patients with community resources to achieve health promotion and disease prevention goals

PC-4 Partners with the patient to address issues of ongoing signs, symptoms, or health concerns that remain over time without clear diagnosis despite evaluation and treatment, in a patient-centered, cost-effective manner

**Level 1**
- Acknowledges that patients with undifferentiated signs, symptoms, or health concerns are appropriate for the family physician and commits to addressing their concerns

**Level 2**
- Develops a comprehensive differential diagnosis for patients with undifferentiated signs, symptoms, or health concerns, and prioritizes an appropriate evaluation and treatment plan
- Chooses and limits diagnostic testing and consultations that will change the management of undifferentiated signs, symptoms, or health concerns

**Level 3**
- Facilitates patients’ understanding of their expected course and events that require physician notification
- Identifies the medical and social needs of patients with undifferentiated signs, symptoms, or health concerns
- Utilizes multidisciplinary resources to assist patients with undifferentiated signs, symptoms, or health concerns in order to deliver health care more efficiently

**Level 4**
- Accepts personal responsibility to care for patients with undifferentiated signs, symptoms, or health concerns
- Develops treatment plans that include periodic assessment and that use appropriate community and family resources to minimize the effect of the undifferentiated signs, symptoms, and health concerns for the patient
- Establishes rapport with patients to the degree that patients confidently accept the assessment of an undiagnosed condition

**Level 5**
- Demonstrates comfort caring for patients with long-term undifferentiated signs, symptoms, or health concerns
- Investigates emerging science and uses multidisciplinary teams to care for patients with undifferentiated signs, symptoms, or health concerns
- Contributes to the development of medical knowledge around undifferentiated signs, symptoms, and health concerns

PC-5 Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care

**Level 1**
- Identifies procedures that family physicians perform

**Level 2**
- Performs procedures under supervision, and knows the indications of, contraindications

**Level 3**
- Uses appropriate resources to counsel the patient on the indications, contraindications,

**Level 4**
- Independently performs all procedures required for graduation

**Level 5**
- Seeks additional opportunities to perform or assist with
Demonstrates sterile technique of, complications of, how to obtain informed consent for, procedural technique for, post-procedure management of, and interpretation of results of the procedures they perform.

Begins the process of identifying additional procedural skills he or she may need or desire to have for future practice.

Identifies and actively seeks opportunities to assist with or independently perform additional procedures he or she will need for future practice.

Counsels the patient regarding indications, contraindications, and complications of procedures commonly performed by other specialties.

Identifies a plan to acquire additional procedural skills as needed for practice.

Identifies procedures identified as areas of need within the community.
**MEDICAL KNOWLEDGE**

The practice of family medicine demands a broad and deep fund of knowledge to proficiently care for a diverse patient population with undifferentiated health care needs.

**MK-1 Demonstrates medical knowledge of sufficient breadth and depth to practice family medicine**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Demonstrates the capacity to improve medical knowledge through targeted study</th>
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<tbody>
<tr>
<td>Level 2</td>
<td>Uses the American Board of Family Medicine (ABFM) In-Training Assessment resident scaled score to further guide his or her education</td>
</tr>
<tr>
<td>Level 3</td>
<td>Demonstrates capacity to assess and act on personal learning needs</td>
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</tbody>
</table>

| Level 4 | Successfully completes ABFM requirements in preparation for certification examination |
| Level 5 | Maintains ABFM certification |

**MK-2 Applies critical thinking skills in patient care**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Recognizes that an in-depth knowledge of the patient and a broad knowledge of sciences are essential to the work of family physicians</th>
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</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>Demonstrates basic decision making capabilities</td>
</tr>
<tr>
<td>Level 3</td>
<td>Recognizes and reconciles knowledge of patient and medicine to act in patients' best interest</td>
</tr>
<tr>
<td>Level 4</td>
<td>Integrates and synthesizes knowledge to make decisions in complex clinical situations</td>
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</tbody>
</table>

| Level 5 | Integrates in-depth medical and personal knowledge of patient, family and community to decide, develop, and implement treatment plans |

| Anticipates expected and unexpected outcomes of the patients' clinical condition and data |
| Integrates and synthesizes knowledge to make decisions in complex clinical situations |
| Uses experience with patient panels to address population health |
| Collaborates with the participants necessary to address important health problems for both individuals and communities |
SYSTEMS-BASED PRACTICE

The stewardship of the family physician helps to ensure high value, high quality, and accessibility in the health care system. The family physician uses his or her role to anticipate and engage in advocacy for improvements to health care systems to maximize patient health.

### SBP-1 Provides cost-conscious medical care

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</thead>
<tbody>
<tr>
<td>Understands that health care resources and costs impact patients and the health care system</td>
<td>Knows and considers costs and risks/benefits of different treatment options in common situations</td>
<td>Coordinates individual patient care in a way that is sensitive to resource use, efficiency, and effectiveness</td>
<td>Partners with patients to consistently use resources efficiently and cost effectively in even the most complex and challenging cases</td>
<td>Role models and promotes efficient and cost-effective use of resources in the care of patients in all settings</td>
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### SBP-2 Emphasizes patient safety

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<tr>
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<tbody>
<tr>
<td>Understands that medical errors affect patient health and safety, and that their occurrence varies across settings and between providers</td>
<td>Recognizes medical errors when they occur, including those that do not have adverse outcomes</td>
<td>Understands the mechanisms that cause medical errors</td>
<td>Consistently engages in self-directed and practice improvement activities that seek to identify and address medical errors and patient safety in daily practice</td>
<td>Role models self-directed and system improvement activities that seek to continuously anticipate, identify and prevent medical errors to improve patient safety in all practice settings, including the development, use, and promotion of patient care protocols and other tools</td>
</tr>
<tr>
<td>Understands that effective team-based care plays a role in patient safety</td>
<td>Understands and follows protocols to promote patient safety and prevent medical errors</td>
<td>Develops individual improvement plan and participates in system improvement plans that promote patient safety and prevent medical errors</td>
<td>Fosters adherence to patient care protocols amongst team members that enhance patient safety and prevent medical errors</td>
<td>Role models self-directed and system improvement activities that seek to continuously anticipate, identify and prevent medical errors to improve patient safety in all practice settings, including the development, use, and promotion of patient care protocols and other tools</td>
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<tr>
<td>Participates in effective and safe hand-offs and transitions of care</td>
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### SBP-3 Advocates for individual and community health

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</thead>
<tbody>
<tr>
<td>Recognizes social context and environment, and how a community’s public policy decisions affect individual and community health</td>
<td>Recognizes that family physicians can impact community health</td>
<td>Identifies specific community characteristics that impact specific patients’ health</td>
<td>Collaborates with other practices, public health, and community-based organizations to educate the public, guide policies, and implement and evaluate community initiatives</td>
<td>Role-models active involvement in community education and policy change to improve the health of patients and communities</td>
</tr>
<tr>
<td>Lists ways in which community characteristics and resources affect the health of patients and communities</td>
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111
Seeks to improve the health care systems in which he or she practices

**SBP-4 Coordinates team-based care**

<table>
<thead>
<tr>
<th>Level 1</th>
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</thead>
<tbody>
<tr>
<td>Understands that quality patient care requires coordination and teamwork, and participates as a respectful and effective team member.</td>
<td>Understands the roles and responsibilities of oneself, patients, families, consultants, and inter-professional team members needed to optimize care, and accepts responsibility for coordination of care.</td>
<td>Engages the appropriate care team to provide accountable, team-based, coordinated care centered on individual patient needs. Assumes responsibility for seamless transitions of care. Sustains a relationship as a personal physician to his or her own patients.</td>
<td>Accepts responsibility for the coordination of care, and directs appropriate teams to optimize the health of patients.</td>
<td>Role models leadership, integration, and optimization of care teams to provide quality, individualized patient care.</td>
</tr>
</tbody>
</table>
PRACTICE-BASED LEARNING AND IMPROVEMENT

The family physician must demonstrate the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

PBLI-1 Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems

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<thead>
<tr>
<th>Level 1</th>
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</thead>
<tbody>
<tr>
<td>Describes basic concepts in clinical epidemiology, biostatistics, and clinical reasoning</td>
<td>Identifies pros and cons of various study designs, associated types of bias, and patient-centered outcomes</td>
<td>Applies a set of critical appraisal criteria to different types of research, including synopses of original research findings, systematic reviews and meta-analyses, and clinical practice guidelines</td>
<td>Incorporates principles of evidence-based care and information mastery into clinical practice</td>
<td>Independently teaches and assesses evidence-based medicine and information mastery techniques</td>
</tr>
<tr>
<td>Categorizes the design of a research study</td>
<td>Formulates a searchable question from a clinical question</td>
<td>Critically evaluates information from others, including colleagues, experts, and pharmaceutical representatives, as well as patient-delivered information</td>
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<tr>
<td>Evaluates evidence-based point-of-care resources</td>
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PBLI-2 Demonstrates self-directed learning

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</thead>
<tbody>
<tr>
<td>Acknowledges gaps in personal knowledge and expertise and frequently asks for feedback</td>
<td>Incorporates feedback and evaluations to assess performance and develop a learning plan</td>
<td>Has a self-assessment and learning plan that demonstrates a balanced and accurate assessment of competence and areas for continued improvement</td>
<td>Identifies own clinical information needs based, in part, on the values and preferences of each patient</td>
<td>Regularly seeks to determine and maintain knowledge of best evidence supporting common practices, demonstrating consistent behavior of regularly reviewing evidence in common practice areas</td>
</tr>
<tr>
<td>Uses feedback to improve learning and performance</td>
<td>Uses point-of-care, evidence-based information and guidelines to answer clinical questions</td>
<td>Demonstrates use of a system or process for keeping up with relevant changes in medicine</td>
<td>Completes ABFM MOC requirements for residents</td>
<td>Initiates or collaborates in research to fill knowledge gaps in family medicine</td>
</tr>
</tbody>
</table>

Consistently evaluates self and practice, using appropriate evidence-based standards, to implement changes in practice | Integrates MOC into ongoing practice assessment and improvement |
Patient Care Improvement and Delivery (PBLI-3)

Improves systems in which the physician provides care

**Level 1**
Recognizes inefficiencies, inequities, variation, and quality gaps in health care delivery

**Level 2**
Compares care provided by self and practice to external standards and identifies areas for improvement

**Level 3**
Uses a systematic improvement method (e.g., Plan-Do-Study-Act [PDSA] cycle) to address an identified area of improvement.

Uses an organized method, such as a registry, to assess and manage population health.

**Level 4**
Establishes protocols for continuous review and comparison of practice procedures and outcomes and implementing changes to address areas needing improvement.

**Level 5**
Role models continuous quality improvement of personal practice, as well as larger health systems or complex projects, using advanced methodologies and skill sets.

Role models continuous self-improvement and care delivery improvements using appropriate, current knowledge and best-practice standards.
PROFESSIONALISM

Family physicians share the belief that health care is best organized and delivered in a patient-centered model, emphasizing patient autonomy, shared responsibility, and responsiveness to the needs of diverse populations. Family physicians place the interests of patients first while setting and maintaining high standards of competence and integrity for themselves and their professional colleagues. Professionalization is the developmental process that requires individuals to accept responsibility for learning and maintaining the standards of the discipline, including self-regulating lapses in ethical standards. Family physicians maintain trust by identifying and ethically managing the potential conflicting interests of individual patients, patients' families, society, the medical industry, and their own self-interests.

PROF-1 Completes a process of professionalization

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</thead>
<tbody>
<tr>
<td>Defines professionalism</td>
<td>Recognizes own conflicting personal and professional values</td>
<td>Recognizes that physicians have an obligation to self-discipline and to self-regulate</td>
<td>Embraces the professional responsibilities of being a family physician</td>
<td>Demonstrates leadership and mentorship in applying shared standards and ethical principles, including the priority of responsiveness to patient needs above self-interest across the health care team</td>
</tr>
<tr>
<td>Knows the basic principles of medical ethics</td>
<td>Knows institutional and governmental regulations for the practice of medicine</td>
<td>Engages in self-initiated pursuit of excellence</td>
<td>Develops institutional and organizational strategies to protect and maintain these principles</td>
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</tr>
<tr>
<td>Recognizes that conflicting personal and professional values exist</td>
<td>Demonstrates honesty, integrity, and respect to patients and team members</td>
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PROF-2 Demonstrates professional conduct and accountability

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<tbody>
<tr>
<td>Presents him or herself in a respectful and professional manner</td>
<td>Consistently recognizes limits of knowledge and asks for assistance</td>
<td>Recognizes professionalism lapses in self and others</td>
<td>Maintains appropriate professional behavior without external guidance</td>
<td>Models professional conduct placing the needs of each patient above self-interest</td>
</tr>
<tr>
<td>Attends to responsibilities and completes duties as required</td>
<td>Has insight into his or her own behavior and likely triggers for professionalism lapses, and is able to use this information to be professional</td>
<td>Reports professionalism lapses using appropriate reporting procedures</td>
<td>Exhibits self-awareness, self-management, social awareness, and relationship management</td>
<td>Helps implement organizational policies to sustain medicine as a profession</td>
</tr>
<tr>
<td>Maintains patient confidentiality</td>
<td>Completes all clinical and administrative tasks promptly</td>
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**PROF-3 Demonstrates humanism and cultural proficiency**

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<tbody>
<tr>
<td>Consistently demonstrates compassion, respect, and empathy</td>
<td>Displays a consistent attitude and behavior that conveys acceptance of diverse individuals and groups, including diversity in gender, age, culture, race, religion, disabilities, sexual orientation, and gender identity</td>
<td>Incorporates patients' beliefs, values, and cultural practices in patient care plans</td>
<td>Anticipates and develops a shared understanding of needs and desires with patients and families; works in partnership to meet those needs</td>
<td>Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health</td>
</tr>
<tr>
<td>Recognizes impact of culture on health and health behaviors</td>
<td>Elicits cultural factors from patients and families that impact health and health behaviors in the context of the biopsychosocial model</td>
<td>Identifies health inequities and social determinants of health and their impact on individual and family health</td>
<td></td>
<td>Develops organizational policies and education to support the application of these principles in the practice of medicine</td>
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**PROF-4 Maintains emotional, physical, and mental health; and pursues continual personal and professional growth**

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<th>Level 5</th>
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</thead>
<tbody>
<tr>
<td>Demonstrates awareness of the importance of maintenance of emotional, physical, and mental health</td>
<td>Applies basic principles of physician wellness and balance in life to adequately manage personal emotional, physical, and mental health</td>
<td>Actively seeks feedback and provides constructive feedback to others</td>
<td>Appropriately manages situations in which maintaining personal emotional, physical, and mental health are challenged</td>
<td>Optimizes professional responsibilities through the application of principles of physician wellness to the practice of medicine</td>
</tr>
<tr>
<td>Recognizes fatigue, sleep deprivation, and impairment</td>
<td>Balances physician well-being with patient care needs</td>
<td>Recognizes signs of impairment in self and team members, and responds appropriately</td>
<td></td>
<td>Maintains competency appropriate to scope of practice</td>
</tr>
</tbody>
</table>
COMMUNICATION

The family physician demonstrates interpersonal and communication skills that foster trust, and result in effective exchange of information and collaboration with patients, their families, health professionals, and the public.

C-1 Develops meaningful, therapeutic relationships with patients and families

Level 1 Recognizes that effective relationships are important to quality care

Level 2 Creates a non-judgmental, safe environment to actively engage patients and families to share information and their perspectives

Level 3 Effectively builds rapport with a growing panel of continuity patients and families

Level 4 Connects with patients and families in a continuous manner that fosters trust, respect, and understanding, including the ability to manage conflict

Level 5 Role models effective, continuous, personal relationships that optimize the well-being of the patient and family

C-2 Communicates effectively with patients, families, and the public

Level 1 Recognizes that respectful communication is important to quality care

Level 2 Matches modality of communication to patient needs, health literacy, and context

Level 3 Negotiates a visit agenda with the patient, and uses active and reflective listening to guide the visit

Level 4 Educates and counsels patients and families in disease management and health promotion skills

Level 5 Role models effective communication with patients, families, and the public

Level 6 Engages community partners to educate the public

Level 7 Engages community partners to educate the public

Identifies physical, cultural, psychological, and social barriers to communication

Organizes information to be shared with patients and families

Participates in end-of-life discussions and delivery of bad news

Recognizes non-verbal cues and uses non-verbal communication skills in patient encounters

Effectively communicates difficult information, such as end-of-life discussions, delivery of bad news, acknowledgement of errors, and during episodes of crisis

Maintains a focus on patient-centeredness and integrates all aspects of patient care to meet patients' needs
### C-3 Develops relationships and effectively communicates with physicians, other health professionals, and health care teams

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>Understands the importance of the health care team and shows respect for the skills and contributions of others</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>Demonstrates consultative exchange that includes clear expectations and timely, appropriate exchange of information</td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td>Effectively uses Electronic Health Record (EHR) to exchange information among the health care team</td>
</tr>
<tr>
<td><strong>Level 4</strong></td>
<td>Sustains collaborative working relationships during complex and challenging situations, including transitions of care</td>
</tr>
<tr>
<td><strong>Level 5</strong></td>
<td>Role models effective collaboration with other providers that emphasizes efficient patient-centered care</td>
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- Demonstrates consultative exchange that includes clear expectations and timely, appropriate exchange of information
- Effectively uses Electronic Health Record (EHR) to exchange information among the health care team
- Sustains collaborative working relationships during complex and challenging situations, including transitions of care
- Role models effective collaboration with other providers that emphasizes efficient patient-centered care

### C-4 Utilizes technology to optimize communication

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>Recognizes effects of technology on information exchange and the physician/patient relationship</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>Ensures that clinical and administrative documentation is timely, complete, and accurate</td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td>Maintains key patient-specific databases, such as problem lists, medications, health maintenance, chronic disease registries</td>
</tr>
<tr>
<td><strong>Level 4</strong></td>
<td>Effectively and ethically uses all forms of communication, such as face-to-face, telephonic, electronic, and social media</td>
</tr>
<tr>
<td><strong>Level 5</strong></td>
<td>Stays current with technology and adapts systems to improve communication with patients, other providers, and systems</td>
</tr>
</tbody>
</table>

- Recognizes effects of technology on information exchange and the physician/patient relationship
- Ensures that clinical and administrative documentation is timely, complete, and accurate
- Maintains key patient-specific databases, such as problem lists, medications, health maintenance, chronic disease registries
- Effectively and ethically uses all forms of communication, such as face-to-face, telephonic, electronic, and social media
- Stays current with technology and adapts systems to improve communication with patients, other providers, and systems
Curricular Expectations

Church Health (CH) Continuity Clinic/ Family Medicine Practice (FMP)

The objectives of the Resident CH Clinic experience are to develop skills in comprehensive Family Medicine care. The primary principles of Family Medicine which include providing continuous, comprehensive and coordinated care to patients and their families and to the community will be emphasized.

Resident Responsibilities

Rotation Preparation: Competency on Electronic Medical Record (EMR)

Report Times: The morning residency clinic starts at 8:00 AM. It is expected that each resident 'huddle' with their clinic Medical Assistant (MA) prior to seeing the first patient. “Huddle” refers to meeting with the MA at least 10 minutes BEFORE the first patient is scheduled, to discuss the patients scheduled for that day and any anticipated needs/problems/procedures. This communication is vital to ensuring good communication and TEAMWORK for our patient care. This should be repeated before the afternoon session.

Supervising and Reporting Structure:

The First year Family Medicine resident will discuss with the faculty preceptor as each patient is seen. The faculty preceptor will then see the patient with the resident (Direct Supervision). Once the resident has been evaluated by the Clinical Competency Committee (CCC) to have attained ACGME Milestone Competency Level 2, faculty need not see every patient with the resident.

Requirement for Direct Supervision will continue for complex level of service, as required by insurance and at the discretion of faculty and resident.

Second and Third year residents will discuss all patient cases with the faculty preceptor, with the ability to see more than one patient before presenting to faculty preceptor. Faculty will not necessarily see each patient, except as noted above (Indirect Supervision with faculty immediately available).

All resident charts will be sent to preceptor for review/signing.

Administrative Responsibilities for the Resident in the Residency Clinic:

For each patient seen in the Residency Clinic:

Collaboration with clinic staff is essential

All notes need to be completed within 24 hours unless extenuating circumstances occur.

All lab orders and simple radiological studies (with their diagnoses) will be ordered per clinic protocol

All complicated radiological studies, referrals, and other out-patient procedures are to be entered in EMR and forwarded to scheduler.

Results of Diagnostic Studies need to be communicated to patient in a timely manner, by either phone call or letter, both of which must be documented in clinic EMR.

Procedural Responsibilities:

Goals:

Family Medicine residents should become competent in those procedures which are within the scope of the specialty.

Objectives:
Curricular Expectations

Recognize the varying documentation requirements for procedure competence by hospitals and accrediting agencies.

Devise a credentialing process to establish a resident’s competence in performing a procedure independently.

Note: RESIDENTS MUST DOCUMENT ALL PROCEDURES IN NEW-INNOVATIONS. If in doubt, document what occurred in the particular procedure. It can be removed later if needed.

Skills:

- Anesthesia for office procedures
- Anoscopy
- Arthrocentesis of major joints.
- Biopsy/excision
- Skin lesions
- Punch biopsy
- Excisional biopsy
- Excision of minor cutaneous and subcutaneous structures
- Mucous membrane lesions
- Bursa Aspiration and Injection
- Cerumen removal
- Cryosurgery
- Endocervical curetage
- Endometrial Biopsy and sampling
- Fracture management
- Hemorrhoid/Thrombus enucleation
- Incision and Drainage of Abscess, Cyst, Hematoma
- Joint Dislocation/Reduction (if able without conscious sedation)
  - Temporomandibular
  - Finger
  - Patella
  - Radial Head
  - Thumb
  - Toe
- Laceration Repair
  - Simple
  - Complex
  - Infected
  - Tendon
- Nail Surgery
- Avulsion
- Debridement
- Excision
- Nasal Cautery and Packing
- Ocular Foreign Body removal
- Pulmonary Function Testing
- Skin Tag Removal
- Wart treatment
  - Non-genital
Curricular Expectations

Interpretive Responsibilities:
- X-Ray interpretation
- Chest
- Extremity
- Joints
- Spine
- Abdomen
- ECG interpretation

Other Core Skills:
- Emotional preparation for, and a sensitive thorough performance of, any patient who presents to a family physician
- A non-judgmental awareness of your patient’s desire to be treated in a caring and efficient manner
- An awareness of the non-medical factors that can affect a patient’s health:
  - Income
  - Family Status
  - Race
  - Gender
  - Occupation
- Followed AIDET format for clinic visit:
  - Acknowledge (greeted the patient and family)
  - Introduce (introduced self to patient/family)
  - Duration (clarified expected length of visit/procedure)
  - Explain (provided thorough information with common terms)
  - Thank (thanked patient/family for coming in, taking care of self, etc.)

Understanding of the Church Health Model for Healthy Living:
- Friends and Family
- Faith Life
- Movement
- Medical
- Work
- Emotional
- Nutrition

ACGME Competencies for CH/FMP Continuity Clinic:

Refer to prior General Competency Expectations, and specific Medical Knowledge requirements below;

Refer to The Church Health Continuity Clinic evaluation form following the Specific Objectives to note specific Competency Based Goals/Skills that will be evaluated quarterly on residents by supervising faculty. Please note additional Goals/Skills for PGY 2 and 3.

Results of the Quarterly Clinic Evaluation will be forwarded to the semi-annual meeting of the Clinical Competency Committee and be used in determining Resident Milestone Progress.

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
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<tr>
<th>Curricular Expectations</th>
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<tbody>
<tr>
<td><strong>BLS. ACLS protocols</strong></td>
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<tr>
<td><strong>PALS protocols</strong></td>
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</table>

**Medical Knowledge**

**Subject Areas**

**Infectious & Parasitic Disease**
- Herpes Simplex
- Herpes Zoster
- Infectious Mononucleosis
- Strep Throat
- Viral infections
- Warts

**Direct Observation**
**Annual In-service Training Exam**
**Meet expected competency level on Rotation Evaluation / Milestones**

**Neoplasms**
- Neoplasms of the skin
- Solid tumors
- Blood and lymphatic cancers

**Direct Observation**
**Annual In-service Training Exam**
**Meet expected competency level on Rotation Evaluation / Milestones**

**Endocrine, Nutritional and Metabolic Disorders**
- Diabetes, Type 1 and 2
- Hyperthyroidism
- Hypothyroidism
- Gout
- Hypercholesterolemia
- Hyperlipidemia, mixed
- Obesity and Morbid Obesity

**Direct Observation**
**Annual In-service Training Exam**
**Meet expected competency level on Rotation Evaluation / Milestones**

**Nervous System Disorders**
- Carpal Tunnel Syndrome
- Epilepsy
- Migraine
- Mental Disorders
- Anxiety
- Attention deficit disorder
- Dementia
- Depression

**Direct Observation**
**Annual In-service Training Exam**
**Meet expected competency level on Rotation Evaluation / Milestones**

**Circulatory System**
- Arrhythmias
- Cardiac
- Chest Pain
- Acute Coronary Syndrome

**Direct Observation**
**Annual In-service Training Exam**
**Meet expected competency level on Rotation Evaluation / Milestones**
<table>
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<th>Curricular Expectations</th>
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<tbody>
<tr>
<td>• Angina</td>
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<td>• Congestive heart failure</td>
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<td>• Vascular</td>
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<td>• Hypertension</td>
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<td>• Benign</td>
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<td>• Orthostatic</td>
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<td>• Complex</td>
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<tr>
<th>Respiratory System</th>
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<tbody>
<tr>
<td>• Lower Respiratory System</td>
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<tr>
<td>• Asthma</td>
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<tr>
<td>• Acute Bronchitis</td>
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<tr>
<td>• COPD</td>
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<tr>
<td>• Pneumonia</td>
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<tr>
<td>• Upper Respiratory Tract</td>
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<tr>
<td>• Acute pharyngitis</td>
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<tr>
<td>• Rhinitis, allergic and non-allergic</td>
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<tr>
<td>• Acute sinusitis</td>
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<tr>
<td>• Upper respiratory infection</td>
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<tr>
<td>Direct Observation</td>
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<td>Annual In-service Exam</td>
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<td>Meet expected competency level on Rotation Evaluation / Milestones</td>
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<th>Digestive System</th>
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<tbody>
<tr>
<td>• Melena</td>
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<tr>
<td>• Constipation</td>
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<tr>
<td>• Diverticulosis and Diverticulitis</td>
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<tr>
<td>• Gastritis and ulcer disease</td>
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<tr>
<td>• Gastroenteritis</td>
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<tr>
<td>• Gastroesophageal Reflux Disease</td>
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<tr>
<td>• Hemorrhoids</td>
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<tr>
<td>• Irritable Bowel Syndrome</td>
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<tr>
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<thead>
<tr>
<th>Genitourinary System</th>
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<tbody>
<tr>
<td>• Urinary System Diseases</td>
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<tr>
<td>• Nephrolithiasis</td>
</tr>
<tr>
<td>• Acute Cystitis</td>
</tr>
<tr>
<td>• Hematuria</td>
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<tr>
<td>• Urinary tract infection</td>
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<tr>
<td>• Acute kidney disease</td>
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<tr>
<td>• Chronic kidney disease</td>
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<tr>
<td>• Male Genital Organ Diseases</td>
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<tr>
<td>• Impotence</td>
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<td>• Prostatitis</td>
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<tr>
<td>• Female Genital Organ Diseases</td>
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<td>• Cervical dysplasia</td>
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<td>• Cervicitis</td>
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<tr>
<td>• Vaginitis</td>
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<tr>
<td>Direct Observation</td>
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<tr>
<td>Annual In-service Exam</td>
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<td>Meet expected competency level on Rotation Evaluation / Milestones</td>
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### Curricular Expectations

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Direct Observation</th>
<th>Annual In-service Training Exam</th>
<th>Meet expected competency level on Rotation Evaluation / Milestones</th>
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<tbody>
<tr>
<td><strong>Skin and Subcutaneous Diseases</strong></td>
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<td></td>
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<tr>
<td>- Breast lump</td>
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<tr>
<td>- Disorders of Menstruation</td>
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<tr>
<td>- Amenorrhea</td>
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<td>- Menopausal disorders</td>
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<td>- Menorrhagia and metrorrhagia</td>
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<td>- Acne</td>
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<td>- Actinic keratosis</td>
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<td>- Cellulitis/abscesses</td>
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<td>- Contact dermatitis</td>
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<td>- Eczema</td>
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<td>- Ingrown nail</td>
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<td>- Onychomycosis</td>
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<td><strong>Musculoskeletal and Connective Tissue</strong></td>
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<td>- Arthropathy</td>
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<td>- Fibromyalgia</td>
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<td>- Rheumatoid arthritis</td>
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<td>- Synovitis</td>
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<td>- Pain in limb</td>
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<td>- Back pain</td>
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<td>- Cervical disorder</td>
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<td>- Rotator cuff / shoulder syndrome</td>
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<td><strong>Signs and Symptoms</strong></td>
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<td>- Abdominal Pain</td>
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<td>- Abnormal pap</td>
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<td>- Arthralgia, unspecified</td>
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<td>- Rectal bleeding</td>
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<td>- Chest pain</td>
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<td>- Diarrhea</td>
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<td>- Dizziness</td>
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<td>- Dysphagia</td>
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<td>- Dysuria</td>
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<td>- Localized edema</td>
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<td>- Fatigue</td>
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### Curricular Expectations

<table>
<thead>
<tr>
<th>Injuries and Adverse Effects</th>
<th>Direct Observation</th>
<th>Meet expected competency level on rotation eval / Milestones</th>
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<tbody>
<tr>
<td>Ankle sprain</td>
<td>Annual In-service Training Exam</td>
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<tr>
<td>Foot sprain</td>
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<td>Hand sprain</td>
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<td>Leg sprain</td>
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<td>Neck sprain</td>
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<td>Shoulder and/or upper arm sprain</td>
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<td>Wrist sprain</td>
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<td>Abrasion</td>
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<td>Contusion</td>
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<td>Insect bite</td>
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<td>Open Wound</td>
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<tr>
<th>Other Common Diagnoses</th>
<th>Direct observation</th>
<th>Meet expected competency level on rotation eval / Milestones</th>
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<tbody>
<tr>
<td>Contraception</td>
<td>Annual In-service Training Exam</td>
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<tr>
<td>Wound dressing</td>
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<td>Exposure to an Infectious Disease</td>
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<td>Immunization</td>
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<td>Well Adult Check</td>
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<td>Well Child Check</td>
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<tr>
<th>Preventive Medicine Competencies:</th>
<th>Direct Observation</th>
<th>Meet expected competency level on rotation eval / Milestones</th>
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</thead>
<tbody>
<tr>
<td>Coordinate preventive health care across providers, institutions and governmental agencies</td>
<td>Annual In-service Training Exam</td>
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<tr>
<td>Demonstrate effective and compassionate communication with the patient and his/her family regarding reduction of risk factors and recommendations for screening and disease prevention.</td>
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<tr>
<td>Curricular Expectations</td>
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<tr>
<td>Identify and access up-to-date, evidence based organizational resources and recommendations for health promotion and disease prevention.</td>
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<td>Demonstrate the acceptance of preventive health principles by modeling a healthy lifestyle.</td>
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<tr>
<td>Perform a detailed history and physical exam with attention to healthy lifestyle promotion and disease prevention.</td>
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<td>Implement or use and existing system for patient recall in the outpatient setting for screening reminders.</td>
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<tr>
<td>Advocate for patients within the current health care and continually strive toward system improvements to improve health maintenance and prevention of disease.</td>
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**Church Health Clinic-Specific Progressive Objectives**

**PATIENT CARE**

**PGY 1**
- Acquires accurate and relevant histories from patients
- Seeks data from secondary sources when needed.
- Performs accurate, appropriate, and thorough physical exam.
- Synthesizes data to prioritize differential diagnosis and problem list.
- Uses collected data to define the central clinical problem
- Verifies data collected by others as appropriate
- Demonstrates good organizational skills resulting in timely completion of tasks.
- Efficient management of straightforward patients.
- Recognizes situations requiring urgent or emergent care.
- Encourages patient/family involvement in the creation and/or maintenance of the patient's plan of care.

**PGY 2 / 3 will include above and below:**
- Able to ensure patient safety and quality care with indirect supervision
- Able to manage complex patients
- Able to supervise care provided by junior residents or students
- Teaches and supervises the performance of procedures
- Appropriately weighs recommendations from consultants in order to effectively manage patient care.

**MEDICAL KNOWLEDGE**

**PGY 1**
- Interprets basic diagnostic tests accurately
- Fully understand the rationale and risks associated with common procedures
Curricular Expectations

PGY 2 / 3 will include above and below:

- Discusses tests, diagnosis, treatment options, and outcomes with patient/family and answered all questions displaying thorough medical knowledge of subjects.
- Interprets complex diagnostic tests accurately
- Possesses the scientific, socioeconomic, and behavioral knowledge required to provide care for complex medical conditions

SYSTEMS-BASED PRACTICE

PGY 1

- Synthesizes and presents information clearly to supervising physician
- Displays a willingness to receive feedback and implement suggestions for improvement regarding patient safety.
- Uses Electronic Medical Records (EMR) accurately and efficiently.
- Recognizes potential errors and understands procedure for reporting errors and near-misses.
- Understand the roles and responsibilities of and effectively partners with all members of the team

PGY 2 / 3 will include above and below:

- Recognizes/ reports system errors and advocates for system improvements
- Able to identify patient care resources without assistance.
- Partners with patient/family to coordinate an appropriate plan of care that is sensitive to the patient's physical needs and financial resources.
- Incorporates cost-awareness principles into standard clinical judgments and decision-making, including screening tests.
- Anticipates needs of patient, caregivers, and future care providers and takes appropriate steps to address those needs.

PROFESSIONALISM

PGY 1

- Is available and responsive to the needs and concerns of patients, caregivers, and members of interprofessional team to ensure safe and effective patient care.
- Completes assigned professional responsibilities without questions or the need for reminders.
- Demonstrates self-awareness of limitations by seeking assistance when appropriate.
- Demonstrates a shared awareness of the patient/family's needs and desires and worked to meet those needs.

PGY 2 and 3 will include above and below

- Fosters collegiality that promotes a high-functioning inter-professional team.
- Willingness to assume professional responsibility regardless of the situation.

PRACTICE-BASED LEARNING AND IMPROVEMENT

PGY 1
Curricular Expectations

- Seizes opportunities for learning.
- Willing to receive feedback and instructions about decisions

**PGY 2 and 3 will include above and below**

- Routinely “slows down” to reconsider an approach to a problem, ask for help, or seek new information
- Searches medical information resources efficiently, guided by the characteristic of clinical questions.

**INTERPERSONAL AND COMMUNICATION SKILLS**

**PGY 1**

- Follows AIDET format:
  - Acknowledge (greeted the patient and family)
  - Introduce (introduced self to patient/family)
  - Duration (clarified expected length of visit/procedure)
  - Explain (provided thorough information with common terms)
  - Thank (thanked patient/family for coming in, taking care of self, etc.)
- Notices and follows up on verbal/informational cues.
- Notices and follows up on non-verbal/affective cues.
- Resident guides the patient interview to develop a thorough picture using open-ended but structured questioning techniques

**PGY 2 and 3 will include above and below:**

- Shares decision making across a wide variety of patient care conversations
- Role models effective communication and development of therapeutic relationships in both routine and challenging situations.
- Engages in collaborative communication with all members of the team
- Communication style/rapport with patient and family enhances patient care encounters which results in additional discussions that may have otherwise been missed.

Reviewed 12/9/2014 ALS
Behavioral Health / Mental Health

2 Blocks (4 –week each) during each year

**Location:** Church Health Clinic

**Contact:** Ron McDonald, D.Min., M.Div.

**Clinic:** 1 day / week Continuity Clinic at Church Health

The Church Health seeks to train family practitioners in a holistic approach to health. We developed a seven step “Model for Healthy Living”, which includes these elements: Faith, Medical, Movement, Work, Emotional, Family and Friends, and Nutrition. Our behavioral health practice is particularly concerned with Faith, Work, Family and Friends, and Emotional. Professionally we use terms like vocation, marriage and family systems, psychological/psychiatric, and spirituality.

The **director** of our behavioral health program is Dr. Ron McDonald, a Tennessee Licensed Clinical Pastoral Therapist and a Diplomate (approved supervisor) in the American Association of Pastoral Counselors. He has over thirty years’ experience as a psychotherapist. His main roles with us are (1) providing psychotherapy for our patients, (2) supervising our counseling interns, (3) overseeing the instruction and supervision of our family practice residents in the area of behavior health and “bed-side” manners.

**Goals**

The **goal** of our family medical residency program will be to provide a structured curriculum in which residents are educated in the diagnosis and management of common mental illnesses, behavioral and relationship problems, and deficits of spirit. Specific objectives are the following:

1. Learning to apply DSM V principles in the diagnosis of patients with mental illnesses, mood disorders, anxiety problems, and substance abuse, and knowing how to administer front-line psychiatric drugs as interventions in these problems.
2. Learning how to make effective referrals to psychiatrists, psychotherapists, and life-style coaches.
3. Learning about psychiatric in-patient programs and addiction recovery programs.
4. Learning better ways of listening and the powerful impact feeling heard has on patients.
5. Learning how to manage and help patients in crisis, including suicide intervention.
6. Learning how to recognize, treat, and refer patients who are currently being abused or have been.
7. Recognizing and understanding the spiritual role in healing, and learning how to encourage healthy spirituality.
8. Learning about cultural diversity, how to respect cultural differences, and build bridges between patients who are different.
9. Recognizing and responding appropriately to ethical issues.
10. Learning how to work in our manner of integrating primary care and behavioral health.

**Educational Philosophy**

We approach behavioral health from four perspectives.

1. **Psychiatric:** we understand the categories of mental health disorders in the Diagnostic and Statistical Manual V of the American Psychiatric Association. All medical and psychological providers at the Church Health are expected to be competent in mental health assessment and diagnosis, and residents will have plenty of hands-on experience in this important function, as well as clear and competent supervision.
Curricular Expectations

2. **Relationship Health—Family and Work Systems**: we are aware of the tremendous impact on people that healthy and unhealthy relationships and systems have on them, so we seek to offer corrective relational experiences. This means careful attention to signs of relational dysfunction as well as the careful maintenance of our staff relations. We want our staff to be relationally healthy enough to affect the outcomes of our treatment by the mere fact that healthy people makes others healthier. Furthermore, having on-site marriage and family counseling as well as viewing and discussing it will have a profound impact on residents’ understanding of its help in their medical work.

3. **Spirituality**: patients come to doctors in different stages of their faith development and with faith questions that are often challenged by illness, pain, and loss. We believe that the primary care examination room is the confessional booth in today’s society. Thus we seek to remind every person who attends to the confessions correlated to the pain our patients are experiencing learn ways to convey forgiveness, grace, and peace. The healthy spirituality we seek to foster is meant to help patients take a more courageous and peaceful approach to living through illness and death. This does not mean we impose beliefs on our patients. Instead, we know that spirit, however one might define it, is present whether spoken or unspoken. Furthermore, spirituality is deeply connected to psychological health. Both theology and psychology are concerned with meaning. Theology helps us approach meaning from universal human experiences; psychology from particular personal experiences. We want all our staff and residents to wrestle with these intersections and understand their priestly role with patients.

4. **Substance Abuse, Addictions, and Crisis Management**: many crises patients bring to physicians are a result of catastrophic diagnoses like cancer, serious accidents, etc. A very high percentage of personal crises, however, are directly connected to substance abuse and addictions. Knowing how to spot addictive problems is difficult and essential, for addicts are very good at hiding what is really happening. Detected, physicians and counselors can work at steering addicted patients towards interventions that might change or even save lives. It is an art that depends to a great extent on the equanimity and differentiation of the care-givers. Helping one another during the treatment of patients in crisis is essential, hence the strength and integrity of the community is crucial. This is the arena in which we often see the importance of integrating these four perspectives.

We separate these training and treatment perspectives for diagnostic reasons, but the truth is that every patient is engaged in every one of them any time they see a physician. Our behavioral health’s unifying perspective is that our main task is fairly simple. We must be listeners extraordinaire. Nothing helps a person cope with illness or move towards healing like being heard, and that belief is our guiding light.

We also seek to help residents work together in ways that change a learning group to a learning community. At the heart of this will be case conferences with counseling interns and volunteer counselors and support group meetings. Case conferences will be led by the behavioral health director and include counseling interns and volunteer counselors. At each meeting two clinicians or residents will present a verbatim report of a difficult case, with the primary focus on the communication patterns and how it helps or hinders medical decisions. Together we will ask three kinds of questions:

1. What are you, the physician/clinician, experiencing in the conversation (anxiety, anger, confusion, sadness, etc.)?
2. What exactly happened in the conversation itself (analysis)? Did the physician/clinician and patient connect or miss-connect?
3. What appears to be the result of the interaction?
4. What could be done differently? What results might have happened with different words and approaches?

We want the group to function as a supportive and challenging community, one that knows that no physician can be perfect, but all interactions can be better. Particularly important will be the willingness of each resident to admit to their personal difficulties that are mobilized with difficult patients. We hope that such introspection will become the norm for all our residents so that they grow as people, heal from their own emotional wounds, and become more accepting of patients. We work from the paradox of change: when people feel accepted, they become willing to change. When people
feel unaccepted, they hold onto what they've got...they don’t change. So we want our residents to convey acceptance of
the personhood of the patient without denying the necessity for treatment and changed habits. The case conference will
be a personal and professional experience of what we want our residents to learn how to treat their patients.

The support group will meet at least monthly and be a time for residents to reflect, debrief, support and learn from this
intense experience.

Structure of the Program

Over the three year residency there will be three primary components. During the first and second years there will a
month-long block of time dedicated to behavioral health. It will include didactic overview to orient and instruct our
residents to our particular way of thinking and learning. Second will be field work that exposes residents to homelessness,
adictions, and mental illness through working in settings that help people with these problems. The third year will focus
on guided, mostly independent study to help the resident consolidate the three years of learning and develop sound
methods of exploring behavioral health problems. Residents will have on-going opportunities to work with psychiatrists
and observe psychotherapy, and the behavioral health director will be easily available and accessible to residents.

PGY 1: 4 Week block; ½ day continuity clinic

PGY 2: 1 to 1.5 days in continuity clinic

Residents will be assigned a 4-week block on Behavioral Health. They will be work under Dr. McDonald and have twice
weekly meetings. Residents will immerse themselves in volunteer work in three different areas: homelessness,
adictions, and community mental health centers. This will be reinforced by support groups to discuss their experiences,
plus written reflections on what one has learned will be required each year.

Residents will choose to spend time each week working with the homeless, addicted, or mentally ill in these possible
settings:

- Homelessness: Residents will work at Manna House, Union Mission, the Salvation Army, or Hospitality Hub.
- Addictions: residents will attend public AA, NA, or Alanon, or SLAA meetings twice a week and work one-half day
  a week at Serenity House or Grace House.
- Mental illness: residents will work at a mental health facility associated with the CH Clinic and Baptist (Crisis
  Stabilization Unit, Lakeside, Baptist).

Required Reading will be assigned by one of the above organizations.

The following themes will be introduced and discussed through-out the block. Concepts will be revisited through-out the
3 years during the resident support group.

1. Principles of Counseling: building a healing sanctuary, humility, openness, differentiation, and deepening of the
self (Ron McDonald’s Building the Therapeutic Sanctuary). We will help residents see their role in receiving patient
confessions, maintaining humility when they are treated with reverence, finding the courage to speak the hard
truth, and recognizing the role of personal intrapsychic pilgrimage in the healing process.
2. Simple Diagnosis: anxiety, depression, relationship problems, parent-child problems, OCD, ADHD, dementia,
adictions (DSM). We will help residents use diagnosis in a way that empowers rather than creates victimhood
and powerlessness.
3. Human Development: stages of child development; stages of parenting; stages of adult life (Daniel Levinson’s
Seasons of a Man’s Life and Erik Erikson’s Childhood and Society). We will help residents see patient problems in
the context of psychosocial development.
Curricular Expectations

4. Crisis Intervention and Management: when dysfunctional patterns cave in; revelations of lies; when denial stops working, PTSD (Stuart & Liberman’s *The Fifteen Minute Hour: Practical Therapeutic Interventions in Primary Care*). Residents will learn practical interventions and effective referral techniques.

5. Cultural Wounds: when race, trauma, social unrest, financial losses, declining neighborhoods, fears, and hatred wound (Solomon Northup’s *Twelve Years a Slave* and Michelle Alexander’s *The New Jim Crow*). Residents will dig in depth into two books that expose wounds of our culture.

6. Religion and Morality: beliefs that help, beliefs that wound; morals that constrict, morals that liberate; anxiety and courage (Paul Tillich’s *The Courage to Be*). Residents will explore the role of theology and philosophy in the lives of patients and how to help with confused thinking.

7. Multi-cultural Sensitivity: listening for strengths and recognizing weaknesses in those who come from another culture or speak another language; the role of medical authority in the multi-cultural context (lectures). Residents will be exposed to ways of thinking about differences that give the healer moral clarity.

8. Ethical Dilemmas: feeling our way through the fog of confusion and complications (Doctor’s Medical Ethics Guidelines and some of M.K. Gandhi’s and M.L King’s essays). Residents will explore ethical problems in the shade of gray, helping them think through unclear difficulties.

9. Alcohol and Drugs: addictions, family problems, self-help groups, and the role of the doctor in addictive behaviors (Bill W’s *Alcoholics Anonymous*). Residents will be introduced to the manipulations and desperation of patients’ with A&D problems.

PGY 3

Residents will choose three behavior health subjects (ADHD; Schizophrenia; Eating Disorders; Personality Disorders, OCD, PTSD, addiction, etc.) and write three scholarly papers on each of them. There will be continuing didactics on depression, anxiety, addictions, and family issues. The support group will continue to meet monthly.

Summary

The Church Health will deliver a Family Medicine Residency that fully integrates our Model for Healthy Living’s seven areas of health care into the training residents will receive: (1) medical, (2) nutrition, (3) spirituality, (4) psychological, (5) exercise, (6) vocation, and (7) relationships. The behavioral health component of our residency will provide excellent training in the integration of spirituality, fostering of healthy relationships, and expert competence in the diagnosis and treatment of psychological/psychiatric problems. We will accomplish this with the guidance of a highly competent behavioral health director, the mentoring of our many behavioral health and chaplaincy volunteers, and sharing and learning in didactic classes, supportive groups, and clinical case conferences.

All of our staff are deeply affected by the integrative and supportive approach we have towards the psychological needs, relationship health, and spirituality of patients, and we are confident that residents will find the humble atmosphere of the Church Health to be a unique and special place to learn how to listen better, what to listen for, and ways to respond that open new pathways to health for the patients they will care for.

Ron McDonald, D.Min. 1/13/15
BMH/CH Family Medicine Cardiology Rotation (CARD)

Contacts: Regina Neal, CH/BMH Residency Coordinator
Email: Regina.Neal@BMHCC.org
Phone: (901) 226-1358

Kent Alan Lee, MA, MD, FAAFP, Associate Program Director
Email: Kent.Lee@bmh.md
Phone: (479) 462-3259

4 week/1 block; working at Baptist-Memphis

Schedule: 7AM-7PM (Monday-Saturday)

Clinic: Will have 1 day of Continuity Clinic at Church Health

Goal:
The resident will develop patient care and medical knowledge competencies at the level of a family physician in the care of private patients with cardiologic diseases.

Objectives:
By the end of the Cardiology experience, PGY 3 residents are expected to expand and cultivate skills and knowledge learned during previous training and to achieve the following objective based on the six general competencies. The resident should exhibit an increasing level of responsibility and independency as he/she progresses throughout the year.

<table>
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<tr>
<th>Competency</th>
<th>Required Skills(s)</th>
<th>Teaching Method(s)</th>
<th>Evaluation method(s)</th>
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<tbody>
<tr>
<td>Patient Care</td>
<td>SPECIALTY SPECIFIC OBJECTIVES</td>
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<tr>
<td></td>
<td>Demonstrate proficiency in obtaining a cardiologic history and physical examination</td>
<td>• Clinical Teaching</td>
<td>• Direct feedback</td>
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<td>• Self-Directed Reading</td>
<td>• End-of-rotation eval</td>
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<td>Interpret EKGs and Cardiovascular Imaging</td>
<td>• Clinical Teaching</td>
<td>• Direct feedback</td>
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<td>• Self-Directed Reading</td>
<td>• End-of-rotation eval</td>
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<td>Apply results of cardiac imaging studies to patient care</td>
<td>• Clinical Teaching</td>
<td>• Direct feedback</td>
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<td>• Self-Directed Reading</td>
<td>• End-of-rotation eval</td>
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<td>Diagnose and manage common cardiologic conditions including but not limited to:</td>
<td>• Clinical Teaching</td>
<td>• Direct feedback</td>
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<td>• Atherosclerosis/Coronary Artery Disease</td>
<td>• Self-Directed Reading</td>
<td>• End-of-rotation eval</td>
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<td></td>
<td>• Acute Coronary Syndromes</td>
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<td>• Valvular Heart Disease</td>
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<td>• Cardiomyopathies/CHF</td>
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<td>• Arrhythmias: tachy</td>
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### Curricular Expectations

<table>
<thead>
<tr>
<th>Medical Knowledge</th>
<th>SPECIALTY SPECIFIC OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrhythmias: brady</td>
<td>• Clinical Teaching</td>
</tr>
<tr>
<td>Hypertension</td>
<td>• Self-Directed Reading</td>
</tr>
<tr>
<td>Congenital Heart Disease</td>
<td>• Clinical Teaching</td>
</tr>
<tr>
<td>Stroke and Cerebrovascular Disease</td>
<td>• Self-Directed Reading</td>
</tr>
<tr>
<td>Peripheral Vascular Disease: Arterial</td>
<td>• Clinical Teaching</td>
</tr>
<tr>
<td>Peripheral Vascular Disease: Venous</td>
<td>• Self-Directed Reading</td>
</tr>
<tr>
<td>Syncope</td>
<td>• Direct feedback</td>
</tr>
<tr>
<td></td>
<td>• End-of-rotation eval</td>
</tr>
<tr>
<td>Demonstrate competence in performing stress testing</td>
<td>• Clinical Teaching</td>
</tr>
<tr>
<td>Prepare and present cases well on rounds and in conferences</td>
<td>• Self-Directed Reading</td>
</tr>
<tr>
<td>Maintain detailed, accurate, and legible medical records</td>
<td>• Clinical Teaching</td>
</tr>
<tr>
<td>Obtain a complete medical history and perform a comprehensive cardiovascular physical exam</td>
<td>• Self-Directed Reading</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>• Direct feedback</td>
</tr>
<tr>
<td></td>
<td>• End-of-rotation eval</td>
</tr>
<tr>
<td>Practice Based Learning &amp; Improvement</td>
<td>SPECIALTY SPECIFIC OBJECTIVES</td>
</tr>
<tr>
<td>Develop a thorough understanding of the anatomy, physiology, and pharmacology of the cardiovascular system</td>
<td>• Clinical Teaching</td>
</tr>
<tr>
<td>Develop knowledge of both didactic and clinical understanding of cardiovascular medicine including but not limited to:</td>
<td>• Self-Directed Reading</td>
</tr>
<tr>
<td>• Cardiovascular Anatomy/ Physiology</td>
<td>• Direct feedback</td>
</tr>
<tr>
<td>• Cardiovascular Physical Exam</td>
<td>• End-of-rotation eval</td>
</tr>
<tr>
<td>• Cardiovascular Imaging</td>
<td>• Clinical Teaching</td>
</tr>
<tr>
<td>• ECG Interpretation</td>
<td>• Self-Directed Reading</td>
</tr>
<tr>
<td>• Atherosclerosis/ Coronary Artery Disease</td>
<td>• Direct feedback</td>
</tr>
<tr>
<td>• Acute Coronary Syndromes</td>
<td>• End-of-rotation eval</td>
</tr>
<tr>
<td>• Valvular Heart Disease</td>
<td>• Clinical Teaching</td>
</tr>
<tr>
<td>• Cardiomyopathies/ CHF</td>
<td>• Self-Directed Reading</td>
</tr>
<tr>
<td>• Arrhythmias: tachy</td>
<td>• Direct feedback</td>
</tr>
<tr>
<td>• Arrhythmias: brady</td>
<td>• End-of-rotation eval</td>
</tr>
<tr>
<td>• Hypertension</td>
<td>• Clinical Teaching</td>
</tr>
<tr>
<td>• Congenital Heart Disease</td>
<td>• Self-Directed Reading</td>
</tr>
<tr>
<td>• Syncope</td>
<td>• Direct feedback</td>
</tr>
<tr>
<td>• Cardiovascular Pharmacology</td>
<td>• End-of-rotation eval</td>
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<tr>
<td>See Family Medicine Objectives for a comprehensive list</td>
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</tbody>
</table>
Curricular Expectations

<table>
<thead>
<tr>
<th>Interpersonal &amp; Communication Skills</th>
<th>SPECIALTY SPECIFIC OBJECTIVES</th>
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<tbody>
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<td></td>
<td>See Family Medicine Objectives for a comprehensive list</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Professionalism</th>
<th>SPECIALTY SPECIFIC OBJECTIVES</th>
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<td>See Family Medicine Objectives for a comprehensive list</td>
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</table>

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<tr>
<th>Systems-Based Practice</th>
<th>SPECIALTY SPECIFIC OBJECTIVES</th>
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<td></td>
<td>See Family Medicine Objectives for a comprehensive list</td>
</tr>
</tbody>
</table>

Learning Venues:

The resident will gain didactic and clinical understanding of cardiovascular medicine in a private practice setting with a combination of inpatient and outpatient responsibilities. There will be an expectation of both clinical and research activity. The curriculum is loosely based on the text: Pathophysiology of Heart Disease (5th edition) Editor Leonard S. Lilly. We will discuss 1 topic daily and the resident should read the chapter or relevant materials prior to the didactic session.

1. Cardiovascular Anatomy/Physiology  
2. Cardiovascular Physical Exam  
3. Cardiovascular Imaging  
4. ECG Interpretation  
5. Atherosclerosis/Coronary Artery Disease  
6. Acute Coronary Syndromes  
7. Valvular Heart Disease  
8. Cardiomyopathies/CHF  
9. Arrhythmias: tachy  
10. Arrhythmias: brady  
11. Hypertension  
12. Congenital Heart Disease  
13. Stroke and Cerebrovascular Disease  
14. Peripheral Vascular Disease: Arterial  
15. Peripheral Vascular Disease: Venous  
16. Syncope  
17. Cardiovascular Pharmacology  
18. Research Project

Inpatient consultation service at BMH-Memphis with census of 5-10 patients to be seen daily in the morning. Outpatient office on Wed. 11 a.m. - 4 p.m. and 8 a.m. - 11 a.m. Rounding on inpatients will be according to schedule but generally be 9-10:00 all days except Friday. Opportunities for 1/2 day weekly performing stress tests should be available. There will also be exposure to echocardiography, nuclear imaging, noninvasive vascular lab, Cardiac CT, cardiac catheterization/intervention and peripheral vascular angiography/intervention. The day will generally start around 7:30 a.m. and end around 5:30 p.m.

Reading Resource:

Pathophysiology of Heart Disease, Current Edition
**Curricular Expectations**

**Supervising Physicians & Group**

- Stern Cardiovascular Center
- David Kraus, MD, FACC, FACP
- Steve Gubin, MD, FACC
- 901-271-1000 office

**Competency Evaluation:**

Attainment of Milestone equivalent level 3.5 or greater on end-of-rotation evaluation
BMH/CH Family Medicine Intensive Care Unit Rotation (ICU)

Contacts: Regina Neal, CH/BMH Residency Coordinator
Email: Regina.Neal@BMHCC.org
Phone: (901) 226-1358

Kent Alan Lee, MA, MD, FAAFP, Associate Program Director
Email: Kent.Lee@bmgh.md
Phone: (479) 462-3259

4 week/1 block; working at Baptist-Memphis

Schedule: 7AM-7PM (Monday-Saturday)
Clinic: Will have 1 day of Continuity Clinic at Church Health

Rotation Specific Medical Knowledge Goals:

MUST MANAGE A MINIMUM OF 15 PATIENTS DURING BLOCK, AND DOCUMENT CARE AND PROCEDURES IN NEW INNOVATIONS UNDER CRITACAL CARE MANAGEMENT.

1. The underlying physiologic changes in the various body systems, including diminished homeostatic abilities, altered metabolism, effects of drugs and other changes relating to the critically ill patient.
2. The conditions encountered in the hospital setting that are significantly life-threatening or likely to have significant impact in changing care processes leading to quality improvement and efficiency.
3. The unique modes of presentation of critically ill patients, including altered and nonspecific presentations of diseases.
4. The financial aspects of critical care and the mechanisms by which medical innovations influence health care patterns and decisions.
5. The processes and systems of care that span multiple disease entities and require multidisciplinary input to create quality care and efficiency.
6. The processes and communication required for the safe transition of patients from one clinical setting to another.
7. The formulation of pretest probability using initial history, physical examination and preliminary diagnostic information when available, as well as the relevance of sensitivity and specificity in interpreting diagnostic findings.
8. The evaluation of benefits, harms and financial costs of drug therapies for individual patients as well as recognition of risks of adverse drug events at the time of transfer of care. Reconciliation of documentation of medications at the time of discharge.
9. Equitable health resources for patients and the recognition that over-utilization of resources may not promote patient safety, quality care or satisfaction.
10. The relationship between value, quality, cost and incorporating patient wishes into optimal health care.
11. The sources for the best available evidence to support clinical decisions and process improvements at the individual and institutional level.
12. Advocacy for provision of high quality point-of-care EBM information resources within the institution.
13. The role played by an assisting subspecialist consultant in promoting improved care, optimized resource utilization and enhanced patient safety.
Curricular Expectations

14. The access and interpretation of data, images and other information from available clinical information systems.
15. The use of methods and materials to educate, reassure and empower patients and families to participate in the creation and implementation of a care plan.
16. The clinical practices and interventions that improve patient safety and the effects of recommended interventions across the continuum of care.
17. The common types of health care-associated infections, including the risk factors.
18. The use of hospital antibiogram in delineating antimicrobial resistance patterns and the major resources for infection control information.
19. Medical practice conduct to ensure risk management.

The following clinical conditions are relevant to management of the critically ill adult:

Basic science review:
- Circulation
- Respiration

Renal disease and metabolic disorders:
- Renal failure
- Oliguria
- Acid-base
- Electrolyte abnormalities

Cardiovascular conditions:
- Acute coronary syndromes
- Cardiopulmonary arrest
- Dysrhythmias
- Hypertensive urgency and emergency
- Heart failure
- Cardiac pulmonary edema

Endocrine:
- DKA
- Thyroid storm
- Hyperosmolar nonketotic acidosis
- Adrenal dysfunctions
- Other endocrine emergencies

Hematologic:
- Bleeding disorders
- Coagulopathies
- Transfusion therapy and reactions
- Venous thromboembolic disease

Gastrointestinal:
- Acute abdomen
- Gastrointestinal bleeding
- Hepatic failure
Curricular Expectations

- Pancreatitis

**Pulmonary:**
- Respiratory failure
- ARDS
- Pulmonary embolism
- Pneumonia
- Pulmonary hypertension
- Severe airflow obstruction

**Neurological:**
- Coma
- Mentation disorders
- Cerebral vascular accidents
- Meningitis
- Encephalitis
- Brain and spinal cord trauma and disease
- Seizures
- Movement disorders
- Neurological emergencies
- Analgesia
- Sedation

**Infectious disease:**
- Sepsis
- Antimicrobial therapy
- Immunocompromised patients
- Clostridium difficile and pseudomembranous colitis

**Multi-system:**
- Shock
- Hypothermia
- Hyperthermia
- Rhabdomyolysis
- Multi-system organ failure
- Overdose and poisonings
- Alcohol and drug withdrawal
- Trauma
- Thermal injury

**Perioperative care:**
- Preoperative clearance
- Preoperative antibiotic therapy
- Postoperative management (pain, glycemic control, antibiotics)

**Preventative practices:**
- Alimentary
Curricular Expectations

- Infection control
- Venous thromboembolism
- Decubitus ulcers

Nutrition and metabolism:
- Metabolic requirements
- Enteral and parenteral feeding

Co-existing conditions:
- Obesity
- Pregnancy
- Elderly

End-of-life:
- Palliative care
- Hospice evaluation
- Life support
- Organ donation and transplantation
- Pronouncement of death

Skills:
- ACLS
- Ventilator management, including:
  - X-ray interpretation
  - Non-invasive and invasive ventilation
  - Issues in sedation, paralytic agents and airway management
  - Ventilator failure
  - Weaning from ventilator support

Diagnostic and therapeutic procedures:
- ABGs
- Lumbar puncture
- Thoracentesis
- Arthrocentesis
- Paracentesis
- Catheter placement (arterial line or central venous access)
- Glasgow Coma Scale assessment, CIWA scale (alcohol withdrawal)
- Management of patient monitoring information and technology

Evaluation: Direct observation, oral presentation; ITE, ACLS exam

Expected outcome: Successful completion of rotation assignments: Milestone Level 3-4 on end rotation evaluation; ACLS certified; ITE scores passing over critical care of adult.
BMH/ CH Family Medicine Dermatology Rotation (DERM)

Contacts: Regina Neal, CH/BMH Residency Coordinator  
Email: Regina.Neal@BMHCC.org  
Phone: (901) 226-1358

Kent Alan Lee, MA. MD. FAAFP., Associate Program Director  
Email: Kent.Lee@bmj.md  
Phone: (479) 462-3259

4 weeks with Dr. Alan Tanenbaum at Tanenbaum Dermatology

Contact: Alan Tanenbaum, MD / Tanenbaum Dermatology Center, PLC / 901-761-0500

Schedule: Report to preceptor at specified hour M-F; suggested rounding on weekends, as long as 1 day in 7 off is preserved

Clinic: Continuity Clinic once per week.

Educational Purpose

Skin disorders represent common reasons for patients to visit their physician. Skin disorders may be self-limited but can also represent life-threatening primary disorders or indicate serious internal disorders. Because of their frequency and potential importance, internists should be able to recognize and initiate management of many common dermatologic disorders. Dermatologic disorders often provide clues to environmental and occupational hazards for the individual patient as well as larger population groups. The dermatology rotation is designed to introduce the resident to the principles of dermatologic diagnosis and treatment. During this rotation, residents will see common and sometimes uncommon skin disorders and have an opportunity to participate in learning skin biopsy techniques.

Teaching Methods

Residents participate in the daily office practice of a faculty dermatologist evaluating patients together. Daily didactic sessions provided by the faculty dermatologist include review of assigned teaching slides. Residents are expected to complete the required readings assigned in addition to the rotation reading list so that they can participate fully in these didactic sessions. Residents will apply knowledge of the etiology, pathogenesis, clinical presentation and natural history of dermatologic disorders and will receive instruction in the skills necessary for dermatologic diagnosis.

Disease Mix

The following diseases are particularly emphasized:

A. Diagnosis and management of malignant and premalignant skin lesions.
B. Management of acne.
C. Evaluation and management of rashes.
D. Allergic skin disorders.
E. Dermatologic manifestations of systemic illness.
Patient Characteristics

As is typical of outpatient dermatological practices, patients are generally healthy; however all different socioeconomic groups are represented. Between the attending dermatologist’s private office and the Church Health, a diversity of dermatologic problems in various stages will be seen. The resident can expect to encounter the adolescent with acne, the adult with dermatologic manifestations of systemic illness and the elderly with dermatologic malignancies.

Types of Clinical Encounters

The vast majority of resident clinical encounters are outpatient on this rotation. There are occasional inpatient dermatology consultations, which the resident and attending dermatologist will complete together. The residents are constantly supervised by an onsite faculty dermatologist. During this rotation, residents will observe how a physician’s assistant is utilized in a dermatologist’s practice.

Procedures and Services

Residents participate in decisions to perform and learn various techniques involved in skin biopsies.

Reading List

The following articles from UpToDate are required reading for the Dermatology rotation:

A. Approach to dermatologic diagnosis
B. Approach to the patient with macular skin lesions
C. Approach to the patient with pustular skin lesions
D. Atopic dermatitis
E. Drug eruptions
F. General principles of dermatologic therapy and topical corticosteroid use
G. Keloids
H. Overview of psoriasis
I. Pityriasis rosea
J. Erythema nodosum
K. Metabolic and inherited diseases affecting the skin
L. Tinea versicolor
M. Early syphilis
N. Impetigo; folliculitis; furunculosis; and carbuncles
O. Overview of boils
P. Overview of melanoma
Q. Overview of nonmelanoma skin cancers
R. Primary prevention of melanoma
S. Prognostic factors in melanoma
T. Risk factors for the development of melanoma
U. Screening and early detection of melanoma
V. Treatment of basal cell carcinoma
W. Treatment of cutaneous squamous cell carcinoma
X. Actinic keratosis
Y. Staging work-up for melanoma and follow-up guidelines
Z. USPSTF Guidelines: Screening for skin cancer: Recommendations and rationale.

The following are suggested readings:

A. MKSAP 14 Dermatology
B. Current literature as recommended by supervising attending.
Curricular Expectations

C. The Electronic Textbook of Dermatology. Editor: Rhett Drugge, M.D. New York University
   http://www.telemedicine.org/stamfor1.htm

Pathological Material

Results of skin biopsies and excision of lesions are reviewed with the attending dermatologist. In addition, the dermatologic teaching file received by the resident includes review of the histologic appearance of many pathological conditions.

Method of Evaluation

A. Attending evaluation at month’s end.
B. Review of assigned topics and required readings with the attending dermatologist.
C. Attend all scheduled outpatient sessions.

Resident requirements for completion of the dermatology rotation are as follows:

A. Completion of assigned and required readings with attending review.
B. Attend all scheduled outpatient sessions (not including scheduled absences for vacation, continuity clinic, CME, etc.).
C. Understand the essentials of performing biopsies.
D. Be able to recognize common malignant and pre-malignant skin conditions.
E. Understand the clinical use of topical steroids as well as complications.
F. Understand the principles of management of acne as well as the indications for different treatments.
BMH/ CH Family Medicine Emergent Medicine Rotation (Adult ER)

Contacts: Regina Neal, CH/BMH Residency Coordinator  
email: Regina.Neal@BMHcc.org  
phone: (901) 226-1358

Kent Alan Lee, MA. MD. FAAFP., Associate Program Director  
email: Kent.Lee@bmg.md  
phone: (479) 462-3259

Location: Baptist Memorial Hospital, Memphis Emergency Department

Attendings: TeamHealth Physician Staff (EM & FM physicians)

CH Clinic: 1 day of continuity clinic per week

Residents will work three to five 10-hour ED shifts and one CH continuity clinic day per week. There will be one didactic Wednesday per month on the 4th Wednesday of the four week block. They will also be expected to have successfully completed the BLS (Basic Life Support) and Advanced Cardiac Life Support (ACLS) courses, preferably before the beginning of the rotation.

At the end of each four week block, an evaluation will be sent to the physician sponsor for that rotation, or their representative, to be completed and sent back to the CH/BMH FM residency coordinator for tabulation. If more than one physician participated in resident instruction that month, they may also do an evaluation.

Goals:
The PG1 resident will achieve competency in the triage of all medical emergencies such that correct initial evaluation and management is initiated and appropriate consultation made

The PG2 resident will achieve competency in the diagnosis and management of all medical emergencies equivalent to that of a certified Family Physician

Objectives:
• To learn to provide appropriate physical and emotional care in a cost-effective manner in the ER setting.
• Evaluate, diagnose and treat critically ill patients under the supervision of the attending ER Physician
• To get familiar with protocols for management of most common diagnoses encountered in ER, including end-of-life decisions (the need for advanced directives, difficulties from not having advanced directives, decision tree given such situations)
• Emergency procedures in trauma and non-trauma setting
• Evaluation of occupational and environmental injuries
• Emergency department preparedness for bioterrorism concerns
• Awareness of appropriate barriers to prevent health care workers from communicable diseases is in the ER
• Understanding role and importance of Family Medicine in follow-up after ER visit
Medical Knowledge Topics:
The following Medical Knowledge topics need to be emphasized during the rotation, with evaluation achieved through oral presentations directly with supervising MD's and ITE scores over ER questions. Resident is expected to direct self-study over these topics using the below references and current literature:

1. Airway maintenance
2. Asthma
3. COPD
4. Hypertension – new onset/malignant
5. Electrolyte imbalances and emergencies
6. Arrhythmias
7. Acute exacerbation of CHF
8. Acute myocardial infarction
9. Chest pain
10. Diabetes and diabetic acidosis
11. Fever
12. ENT pathologies in adults/pediatrics
13. Neurologic signs
14. Altered mental status
15. Meningitis
16. Acute abdomen
17. Evaluation of urinary tract infections, pyelonephritis
18. Pelvic inflammatory diseases and sexually transmitted diseases
19. Vaginal bleeding
20. Pregnancy; acute pathologies
21. Labor; acute pathologies
22. Bites and stings
23. Trauma - evaluation and stabilization
24. Shock
25. Examination of extremities
26. Low back pain
27. Evaluation of dislocations, sprains and strains
28. Dental emergencies, peritonsilar abscess, dental and jaw injuries
29. Ophthalmic emergencies - red eye / foreign body/ glaucoma, etc.
30. Headache management
31. Dermatologic emergencies
32. Infections and sepsis
33. Suture techniques
34. Drug overdoses and poisonings
35. Hypothermia
36. Management of psychiatric emergencies
37. Evaluation of abuse victims/required reporting

Resident Responsibilities:

- Documenting the history and physical exam, entering orders and assisting with patient management
- Arrange appropriate patient follow-up under supervision of ER physician
- Familiarize themselves with protocols used in ER setting for common diagnoses
Curricular Expectations

- Every patient will be discussed with and/or seen with the ER physician, including discussion of the presentation, appropriate diagnostic testing, differential diagnoses, consultations, and treatment plan.
- Participation in the care of the entire breadth of disorders – Neonatal to Geriatric, including OB/Gyn.

Rotation Preparation:

- Read curriculum policy manual at least 2 weeks prior to starting rotation.
- Verify assigned shifts regarding upcoming rotation.

Recommended Reading:

- Handbook of Diagnosis Status and Treatment in the Emergency Department
- Emergency Medicine Secrets, 6th ed., V. J. Markovchick
- Sanford Guide to Antimicrobial Therapy, 46th ed., D. Gilbert
- Articles as recommended by Emergency Medicine faculty.

Rotation Schedules:

1 Block each in R1 and R2 years. The Residents have the flexibility to schedule and work the shifts based on best learning opportunities and convenience of timing. The schedules are encouraged to avoid conflicting timings with other Residents schedules in the same department to help maximize hands on experience and learning.

Procedural Responsibilities:

*** Recording and documentation of all observed, assisted and performed procedures ***

Develop competence in the interpretation:

1. ECG
2. Chest x-rays
3. Incentive spirometry
4. CT scans
5. MRI scans

Participate and develop competency in:

1. Advanced Life Support
2. Interpretation and Treatment of Cardiac Arrhythmias such as but not limited to SVT, V-Fib, Bradycardia, Asystole, VTach
3. Intravenous puncture: Peripheral, External Jugular, Subclavian, Internal Jugular
4. Intubation: Endotracheal, Nasotracheal, Nasogastric
5. Heimlich’s Maneuver
6. Thoracentesis
7. Lumbar Puncture
8. Laceration repairs
9. Slit Lamp exam
10. Ocular tonometry
11. Indirect Laryngoscopy
14. Splint Application: Arm/Short, Leg/Short
15. Aspiration of Joint: Knee, Elbow
16. Surgical Debridement
17. Preservation of Severed Extremities (e.g. ear, extremities, nose, penis)
18. Immobilization Techniques and Transportation: Spinal Trauma, fractures
19. Treatment of Minor Bums
20. Urethral Catheterization
BMH/CH Family Medicine Emergent Pediatrics Rotation (Peds ER)

Contacts: Regina Neal, CH/BMH Residency Coordinator  
email: Regina.Neal@BMHcc.org  
phone: (901) 226-1358  

Kent Alan Lee, MA, MD, FAAFP, Associate Program Director  
email: Kent.Lee@bmg.md  
phone: (479) 462-3259  

Location: Baptist Memorial Hospital for Women, Pediatric Emergency Department

Attendings: TeamHealth Physician Staff (EM & FM physicians)

CH Clinic: 1 day of continuity clinic per week

Residents will work three or four 10-hour ED shifts and one CH continuity clinic day per week. There will be one didactic Wednesday per month on the 4th Wednesday of the four week block. They will also be expected to have successfully completed the BLS (Basic Life Support) and Pediatric Advanced Life Support (PALS) courses, preferably before the beginning of the rotation.

At the end of each four week block, an evaluation will be sent to the physician sponsor for that rotation, or their representative, to be completed and sent back to the CH/BMH FM residency coordinator for tabulation. If more than one physician participated in resident instruction that month, they may also do an evaluation.

Goals

- By the end of the rotation, residents should be able to:
- Diagnose and manage common non-life threatening conditions encountered in the pediatric emergency room.
- Discuss theory and practice of fluid management in mildly to severely dehydrated infants and children, and perform
- List risk factors and mechanisms for common childhood injuries.
- Discuss methods for preventing these common childhood injuries.
- Demonstrate proper anesthesia and suturing skills.
- Compile a procedural log of all patient care experience during the rotation

Materials for review/study:

- Emergency Medicine Secrets, 8th ed., V. J. Markovchick
- Sanford Guide to Antimicrobial Therapy, 46th ed., D. Gilbert
- AFP articles on specific pediatric emergency topics
### PATIENT CARE

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<thead>
<tr>
<th>Specific Objective</th>
<th>Measurement tool</th>
<th>Expected Outcome</th>
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<tbody>
<tr>
<td>Learners will:</td>
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<tr>
<td>• Provide compassionate, appropriate and effective care to children in the Pediatric Emergency Department</td>
<td>• Direct observation</td>
<td>• Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>• Demonstrate an ability to work inclusively with other health care professionals in the care of children with acute illnesses and injuries.</td>
<td>• Global (360°) evaluations</td>
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<tr>
<td>• Discuss management of intravenous fluids in a dehydrated child</td>
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<tr>
<td>• Participate in the care of patients with common pediatric conditions, such as, but not limited to:</td>
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</tr>
<tr>
<td>› Asthma exacerbation</td>
<td>• Direct observation</td>
<td>• Global (360°) evaluations</td>
</tr>
<tr>
<td>› Dehydration</td>
<td>• Global (360°) evaluations</td>
<td></td>
</tr>
<tr>
<td>› Gastroenteritis</td>
<td></td>
<td></td>
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<tr>
<td>› Febrile seizure</td>
<td>• Direct observation</td>
<td>• Global (360°) evaluations</td>
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<tr>
<td>› Diabetic ketoacidosis</td>
<td>• Global (360°) evaluations</td>
<td></td>
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<tr>
<td>› Sprains, strains and fractures</td>
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<td>Motor vehicle collision or trauma</td>
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### MEDICAL KNOWLEDGE

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Measurement tool</th>
<th>Expected Outcome</th>
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<tbody>
<tr>
<td>Learners will be able to:</td>
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<tr>
<td>• Use appropriate evidence-based resources to access information about care of routine conditions seen in the pediatric ED</td>
<td>• Direct observation</td>
<td>• Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>• Calculate intravenous fluid replacement for dehydrated infants and children</td>
<td>• Global (360°) evaluations</td>
<td>• Scores on resident in-training exam (ITE) which are above the national average for year of training</td>
</tr>
<tr>
<td>• List the most common types of illness and injuries by age group</td>
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<tr>
<td>• Discuss counseling strategies for pediatric safety (helmets; pads; seat belts; pool safety; gun safety)</td>
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<tr>
<td>• Discuss common management strategies for the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>› Asthma</td>
<td>• Direct observation</td>
<td>• Global (360°) evaluations</td>
</tr>
<tr>
<td>› Pneumonia</td>
<td>• Global (360°) evaluations</td>
<td></td>
</tr>
<tr>
<td>› Gastroenteritis</td>
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</tr>
<tr>
<td>› Common childhood injuries/trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>› Common sprains/strains/fractures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>› Workup of suspected child abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>› Urinary tract infection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PRACTICE-BASED LEARNING AND IMPROVEMENT

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Measurement tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learners will:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Demonstrate ability to incorporate new knowledge acquired from current guidelines and other evidence-based resources to patient care decisions</td>
<td>• Direct observation</td>
<td>• Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>• List and discuss quality control measures used in the Pediatric Emergency Department</td>
<td>• Global (360°) evaluations</td>
<td></td>
</tr>
<tr>
<td>• Discuss the roles of various ED staff, including paramedics, triage personnel, nursing support, and physicians</td>
<td>• Write-up of literature search of topic chosen by resident and endorsed by faculty</td>
<td></td>
</tr>
<tr>
<td>• Discuss how to contact poison control, child protective services, the rape and domestic violence counselors and other services available to children</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Curricular Expectations

#### INTERPERSONAL AND COMMUNICATION SKILLS

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Measurement tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learners will:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Demonstrate acceptable communication skills when interacting with staff, faculty, patients and students</td>
<td>• Direct observation</td>
<td>• Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>• Complete all exams, write-ups, orders and answer phone calls/pages in a time sensitive manner</td>
<td>• Global (360°) evaluations</td>
<td></td>
</tr>
<tr>
<td>• Communicate effectively and in a patient-centered manner with patients and their families</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PROFESSIONALISM

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Measurement tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learners will:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Demonstrate compliance with confidentiality in all patient care interactions</td>
<td>• Direct observation</td>
<td>• Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>• Complete all charting, orders, procedure notes and answer all pages and requests in a timely fashion</td>
<td>• Global (360°) evaluations</td>
<td></td>
</tr>
<tr>
<td>• Demonstrate appropriate working interactions with faculty, staff and students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Complete all written notes in legible form</td>
<td>• Direct observation</td>
<td></td>
</tr>
<tr>
<td>• Document all procedures in New Innovations at least weekly</td>
<td>• Global (360°) evaluations</td>
<td></td>
</tr>
</tbody>
</table>

#### SYSTEMS-BASED PRACTICE

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Measurement tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learners will:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Discuss community and governmental programs for managing serious safety or welfare issues seen in the pediatric ED</td>
<td>• Direct observation</td>
<td>• Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>• Discuss and develop collegial working relationships with consultants and ED physicians</td>
<td>• Global (360°) evaluations</td>
<td></td>
</tr>
<tr>
<td>• Provide counseling to at least three patients regarding safety practices (e.g. seat belts, play safety; pool safety; smoke detectors; smoke free environment)</td>
<td>• Written reflection</td>
<td></td>
</tr>
</tbody>
</table>
BMH/CH Family Medicine Care of Older Adults Rotation (Geriatrics)

Contacts:
Regina Neal, CH/BMH Residency Coordinator
email: Regina.Neal@BMHcc.org
phone: (901) 226-1358

Kent Alan Lee, MA, MD, FAAFP, Associate Program Director
email: Kent.Lee@bmg.md
phone: (479) 462-3259

1 Block (4 week) experience at multiple locations:
Out-patient Geriatric Office.
Longitudinal experience for monthly at ECF for all three years.
Two week experience focused on rehabilitation in R3 year.

1-2 days/week in continuity clinic at Church Health

Specific Patient Care and Medical Knowledge Objectives:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Method of Assessment</th>
<th>Passing Scores on Rotation Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates and Overall Approach to maintaining the health of a Geriatric Patient</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20000215/1089.html">http://www.aafp.org/afp/20000215/1089.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates Knowledge and Use of Preventative Testing and Screening the in the Elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Demonstrates an awareness of Sexuality in the Elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Demonstrates the ability to assess a Geriatric Patient with Failure to Thrive</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20040715/343.html">http://www.aafp.org/afp/20040715/343.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall risk assessment and prevention</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20050701/81.html">http://www.aafp.org/afp/20050701/81.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.cdc.gov/ncipc/duip/FallsPreventionActivity.htm">http://www.cdc.gov/ncipc/duip/FallsPreventionActivity.htm</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curricular Expectations</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>--------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Demonstrates ability to diagnose and treat Dementia</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20010215/703.html">http://www.aafp.org/afp/20010215/703.html</a></td>
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<tr>
<td><a href="http://www.aafp.org/afp/20031001/1365.html">http://www.aafp.org/afp/20031001/1365.html</a></td>
<td></td>
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</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20020601/2263.html">http://www.aafp.org/afp/20020601/2263.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates Understanding of use Feeding Tubes in the elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Understands Risk and ways to prevent polypharmacy</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Demonstrates and awareness of and appropriate devices to assist gait disorders in the elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Demonstrates strategies for screening for elder or partner abuse</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.annals.org/cgi/content/full/140/5/387">http://www.annals.org/cgi/content/full/140/5/387</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates an awareness of Common infections in older adults and is aware of the latest treatment recommendations</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Treatment of UTI and asymptomatic bacteruria in the elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20060915/985.html">http://www.aafp.org/afp/20060915/985.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates Strategy of Influenza Prevention in the Nursing Home</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20020101/75.html">http://www.aafp.org/afp/20020101/75.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is aware of strategies to Improve Patient Safety in Nursing Homes (Great Power Point Presentation)</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://aging.utoronto.ca/sites/aging.utoronto.ca/files/Wagner.pdf">http://aging.utoronto.ca/sites/aging.utoronto.ca/files/Wagner.pdf</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is Competent at Performing Home Visits</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/991001ap/1481.html">http://www.aafp.org/afp/991001ap/1481.html</a></td>
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</tr>
<tr>
<td>Curricular Expectations</td>
<td>Submitted Encounter Form</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Care of the Patient with PMR and/or Giant Cell Arteritis</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Diagnosis of Age Related Macular Degeneration</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20000515/3035.html">http://www.aafp.org/afp/20000515/3035.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates ability to screen for and treat Osteoporosis in Women</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Demonstrates Management skills for Vertebral Compression Fractures in men</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20040101/111.html">http://www.aafp.org/afp/20040101/111.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates the ability to medically manage a hip fracture</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Demonstrates ability to diagnose and treat edema in the elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20050601/2111.html">http://www.aafp.org/afp/20050601/2111.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Demonstrates ability to treat and manage erectile dysfunction</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20000101/95.html">http://www.aafp.org/afp/20000101/95.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower Extremity Ulcers</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20030815/tips/12.html">http://www.aafp.org/afp/20030815/tips/12.html</a></td>
<td></td>
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</tr>
<tr>
<td>Demonstrates diagnostic and management skills related to abdominal pain in the elderly patient</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20061101/1537.html">http://www.aafp.org/afp/20061101/1537.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curricular Expectations</td>
<td>Observation Method</td>
<td>Evaluation Method</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Diagnosis and management of osteoarthritis</td>
<td>Direct Observation</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20000315/1795.html">http://www.aafp.org/afp/20000315/1795.html</a></td>
<td></td>
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</tr>
<tr>
<td>Familiar with 2ndary Prevention of Coronary Heart Disease in the Elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20050615/2289.html">http://www.aafp.org/afp/20050615/2289.html</a></td>
<td></td>
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</tr>
<tr>
<td>Demonstrates ability to Diagnose and Treat Depression in the Elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20040515/2375.html">http://www.aafp.org/afp/20040515/2375.html</a></td>
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<td><a href="http://www.aafp.org/afp/20020915/1001.html">http://www.aafp.org/afp/20020915/1001.html</a></td>
<td></td>
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</tr>
<tr>
<td>Demonstrates strategies for pneumonia prevention and treatment in long term care facilities</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20041015/1495.html">http://www.aafp.org/afp/20041015/1495.html</a></td>
<td></td>
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</tr>
<tr>
<td>Demonstrates diagnostic and management skills for sleep disorders in the elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/990501ap/2551.html">http://www.aafp.org/afp/990501ap/2551.html</a></td>
<td></td>
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</tr>
<tr>
<td>Demonstrates diagnostic and management skills for incontinence in the elderly</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/980600ap/weiss.html">http://www.aafp.org/afp/980600ap/weiss.html</a></td>
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<td><a href="http://www.aafp.org/afp/20001201/2433.html">http://www.aafp.org/afp/20001201/2433.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates diagnostic and management skills for Herpes Zoster/Shingles</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20050915/1075.html">http://www.aafp.org/afp/20050915/1075.html</a></td>
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<td><a href="http://www.aafp.org/afp/20070615/steps.html">http://www.aafp.org/afp/20070615/steps.html</a></td>
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</tr>
<tr>
<td>Management of SBE prophylaxis</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/980201ap/taubert.html">http://www.aafp.org/afp/980201ap/taubert.html</a></td>
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</tr>
<tr>
<td>DVT diagnosis and treatment</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20040615/2829.html">http://www.aafp.org/afp/20040615/2829.html</a></td>
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<tr>
<td><a href="http://www.aafp.org/afp/20040615/2841.html">http://www.aafp.org/afp/20040615/2841.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Operative Fever</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>- Wind--pneumonia, atelectasis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Water--urinary tract infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Wound--wound infections</td>
<td></td>
<td></td>
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<tr>
<td>- Wonder drugs--especially anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curricular Expectations</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
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</tr>
<tr>
<td>• Walking—walking can help reduce deep vein thromboses and pulmonary embolus</td>
<td></td>
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</tr>
<tr>
<td>Dementia Screens</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20010215/703.html">http://www.aafp.org/afp/20010215/703.html</a></td>
<td></td>
<td></td>
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<tr>
<td><a href="http://www.clinicalgeriatrics.com/article/403">http://www.clinicalgeriatrics.com/article/403</a></td>
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</tr>
<tr>
<td><a href="http://journals.cambridge.org/action/displayAbstract;jsessionid=C8F783A4847036F41CB4BD8379810E4.tomcat17fromPage=online&amp;aid=1359540">http://journals.cambridge.org/action/displayAbstract;jsessionid=C8F783A4847036F41CB4BD8379810E4.tomcat17fromPage=online&amp;aid=1359540</a></td>
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</tr>
<tr>
<td>Fall Risk Screens</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Perioperative Medical Care</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.surgical-tutor.org.uk/default-home.htm?principles/perioperative.htm~right">http://www.surgical-tutor.org.uk/default-home.htm?principles/perioperative.htm~right</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-op cardiac assessment</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://acc.org/qualityandscience/clinical/guidelines/perio/update/periupdate_index.htm">http://acc.org/qualityandscience/clinical/guidelines/perio/update/periupdate_index.htm</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palm Program for Cardiac Clearance</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.statcoder.com/cardiac1.htm">http://www.statcoder.com/cardiac1.htm</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Risk Assessment</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Appropriate use of pre-operative tests for elective surgery</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Parenteral Nutrition Management</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Complete this tutorial</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.csun.edu/~cjh78264/parenteral/introduction.html">http://www.csun.edu/~cjh78264/parenteral/introduction.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Transfusion Guidelines</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td>Transfusion Reaction Diagnosis and Management of</td>
<td>Direct Observation</td>
<td>Passing Scores on Rotation Evaluation</td>
</tr>
<tr>
<td><a href="http://www.emedicine.com/emerg/topic603.htm">http://www.emedicine.com/emerg/topic603.htm</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Passing score on rotation: Milestone Level 3-4 on end of rotation evaluation.*
Gynecology

Gynecology: 1 Block/ 4 weeks

The Gynecology rotation will be completed during the latter half of the R-2 year. The experience will be provided both longitudinally, through experiences in an R-2 continuity clinic as well as during their rotation in a women's health reproductive health clinic that is affiliated with Church Health. Residents will spend 2 days during each week of this rotation seeing patients in their continuity clinic and the other three days working in one of our affiliated Women’s Health clinics.

Rotation objectives

By the end of the clinical gynecology rotation, R2s will be able to:

- Discuss diagnosis and management of basic gynecologic (urogenital and endocrine) conditions that affect women
- Describe and/or perform common office-based procedures, including pelvic exam (pap smear), clinical breast exam, colposcopy, endometrial biopsy, IUD placement and removal
- Discuss current recommendations for the following: gynecologic cancers, preventive health care of women, contraceptive management, management of the climacteric, and issues related to human sexuality.
- Discuss normal anatomy and physiology of the female reproductive tract, including age related changes.
- Discuss the basic endocrinology of reproduction, menses, and menopause.
- Counseling skills for patient and family toward above (and below) mentioned topics.

Resident Responsibilities:

A resident is responsible for being at all clinical sessions and experiential learning sessions during the rotation. The resident will have two full days of CH continuity clinic during the week. Learners should review the curriculum prior to beginning the rotation to make sure that there is a good understanding of expectations. Learners should meet with the curriculum director prior to beginning the rotation to discuss project ideas and go over expectations.

Rotation materials for review:

1. American Family Physicians gynecology articles (in PDF files)
2. Lange: Office Gynecology
3. American College of Obstetrics and Gynecology Gyn Practice Bulletins (in PDF files)
5. Managing Contraception handbook; current edition (available through CH)

<table>
<thead>
<tr>
<th>PATIENT CARE</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Objective</td>
<td>Direct observation Global (360°) evaluations</td>
<td>Passing scores on rotation evaluations</td>
</tr>
<tr>
<td>Learners will: Provide compassionate, appropriate and effective care to women seeking gynecologic care</td>
<td></td>
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<tr>
<td></td>
<td>Demonstrate decision making in terms of which patients require referral to a gynecologist</td>
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<tr>
<td></td>
<td>Demonstrate the ability to perform a pap smear with bimanual exam, speculum exam, and clinical breast exam.</td>
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<tr>
<td></td>
<td>Demonstrate the ability to perform a wet prep and discuss common findings</td>
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</tbody>
</table>
### Curricular Expectations

- Demonstrate the ability to perform an endometrial biopsy and/or cervical polyp removal
- Demonstrate the ability to list risks and benefits as well as contraindications for hormone therapy
- Demonstrate the ability to insert and remove various intrauterine devices
- Perform appropriate contraceptive counseling
- List and discuss indications for diaphragm use and fitting
- Discuss and observe and/or perform cervical cryotherapy
- Discuss and observe and/or perform LEEP

### MEDICAL KNOWLEDGE

<table>
<thead>
<tr>
<th>Specific objective</th>
<th>Measurement tool</th>
<th>Expected outcome</th>
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</thead>
<tbody>
<tr>
<td>Learners will:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Discuss current guidelines for pap screening</td>
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<tr>
<td>- Discuss current guidelines for breast cancer screening and mammography</td>
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<tr>
<td>- Discuss common gynecologist cancers, including epidemiology, presentation, diagnosis and treatment options</td>
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<tr>
<td>- Discuss common type of contraception, including diaphragms, cervical caps, condoms, IUD/IUS, and COCs</td>
<td>Direct observation</td>
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<tr>
<td>- Discuss risk factors for intimate partner violence (IPV) and screening options for it</td>
<td>Global (360°) evaluations</td>
<td></td>
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<tr>
<td>- Discuss management/health care issues of patients who are lesbian, bisexual, or transgender</td>
<td>Write-up of literature search of topic chosen by resident and endorsed by faculty</td>
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<tr>
<td>- Discuss basic reproductive physiology</td>
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<tr>
<td>- Discuss management strategies for dysfunctional uterine bleeding</td>
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<tr>
<td>- Discuss diagnosis and management of the following common gynecologic conditions</td>
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<tr>
<td>- Breast diseases (benign and malignant)</td>
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<tr>
<td>- Amenorrhea/Ectopic pregnancy/unwanted pregnancy</td>
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<tr>
<td>- Gynecologic endocrinology (contraceptive methods, PCOS)</td>
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<tr>
<td>- Chronic pelvic pain, including endometriosis</td>
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<td>- Menopause and hormone therapy</td>
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<td>- Cervical cancer</td>
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<td>- Vulvar and vaginal cancer</td>
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<td>- Uterine cancer</td>
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<tr>
<td>- Ovarian cancer</td>
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<tr>
<td>- Urinary incontinence</td>
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<tr>
<td>- Osteoporosis</td>
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<tr>
<td>- Infections of the reproductive tract/vaginitis/PID</td>
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<tr>
<td>- Benign and malignant neoplasms</td>
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</table>

### PRACTICE-BASED LEARNING AND IMPROVEMENT

<table>
<thead>
<tr>
<th>Specific objective</th>
<th>Measurement tool</th>
<th>Expected outcome</th>
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</thead>
<tbody>
<tr>
<td>Learners will:</td>
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<tr>
<td>- Demonstrate the ability to search out current guidelines on women’s routine health maintenance using online sources</td>
<td>Direct observation</td>
<td>Passing scores on rotation evaluations</td>
</tr>
<tr>
<td></td>
<td>Global (360°) evaluations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Write-up of literature search of topic chosen by resident and endorsed by faculty</td>
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</table>

### INTERPERSONAL AND COMMUNICATION SKILLS

<table>
<thead>
<tr>
<th>Specific objective</th>
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</table>
### Curricular Expectations

<table>
<thead>
<tr>
<th>Specific objective</th>
<th>Measurement tool</th>
<th>Expected outcome</th>
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</thead>
<tbody>
<tr>
<td><strong>Learners will:</strong></td>
<td>Direct observation Global (360°) evaluations</td>
<td>Passing scores on rotation evaluations</td>
</tr>
<tr>
<td>• Demonstrate acceptable communication skills when interacting with staff, faculty, patients and students</td>
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<tr>
<td>• Complete all exams, write-ups, orders and answer phone calls/pages in a time sensitive manner</td>
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<tr>
<td>• Communicate effectively and in a patient-centered manner with patients and their families</td>
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</table>

**PROFESSIONALISM**

<table>
<thead>
<tr>
<th>Specific objective</th>
<th>Measurement tool</th>
<th>Expected outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learners will:</td>
<td>Direct observation Global (360°) evaluations</td>
<td>Passing scores on rotation evaluations</td>
</tr>
<tr>
<td>• Demonstrate compliance with confidentiality in all patient care interactions</td>
<td></td>
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<tr>
<td>• Complete all charting, orders, procedure notes and answer all pages and requests in a timely fashion</td>
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<tr>
<td>• Demonstrate appropriate working interactions with faculty, staff and students</td>
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<tr>
<td>• Complete all written notes in legible form</td>
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<tr>
<td>• Document all procedures in New Innovations daily</td>
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</tbody>
</table>

**SYSTEMS-BASED PRACTICE**

<table>
<thead>
<tr>
<th>Specific objective</th>
<th>Measurement tool</th>
<th>Expected outcome</th>
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</thead>
<tbody>
<tr>
<td>Learners will:</td>
<td>Direct observation Global (360°) evaluations</td>
<td>Passing scores on rotation evaluations</td>
</tr>
<tr>
<td>• Participate in seminars at local systems that provide women’s health care (women’s shelter, IPV support groups, etc.)</td>
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<tr>
<td>• List options for women who are victims of rape to receive care and/or shelter</td>
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<td>• Discuss how poverty, homelessness, immigrant status and access to contraception influence women’s health care</td>
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<tr>
<td>• Discuss gynecologic conditions which require referral to higher levels of care and how to establish/develop these specialist referral patterns</td>
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### Procedural Documentation:

Faculty will observe residents on all procedural training. **Documentation of all observed, assisted and performed procedures is to be completed daily in New-Innovation. Precepting faculty should sign off on logs weekly.**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Minimum number for competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap smear</td>
<td>10 and as observed by preceptor</td>
</tr>
<tr>
<td>Bartholin’s cyst drainage/ Word catheter placement</td>
<td>Exposure and workshop discussion only</td>
</tr>
<tr>
<td>Colposcopy and biopsy</td>
<td>5 which include biopsy</td>
</tr>
<tr>
<td>LEEP</td>
<td>2 (elective)</td>
</tr>
<tr>
<td>Endometrial biopsy</td>
<td>2</td>
</tr>
<tr>
<td>IUD placement (Mirena &amp; Paragard)</td>
<td>6 (3 each)</td>
</tr>
<tr>
<td>Procedure</td>
<td>Count</td>
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<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td>IUD removal</td>
<td>2</td>
</tr>
<tr>
<td>IUD location with ultrasound</td>
<td>2</td>
</tr>
<tr>
<td>Cervical polypectomy</td>
<td>1</td>
</tr>
<tr>
<td>Cryosurgery-cervix</td>
<td>3</td>
</tr>
<tr>
<td>Diaphragm fitting</td>
<td>1</td>
</tr>
<tr>
<td>Genital wart treatment</td>
<td>3</td>
</tr>
</tbody>
</table>

Performance evaluation:

1. Daily observation of the resident’s performance by the attending
2. Discussion with resident about the above topics
3. Attendance at all scheduled office sessions
4. New-Innovation rotation evaluation forwarded to the resident’s file
Health Systems

**1 Blocks (4 –weeks each) during each year**

**Location:** Church Health Clinic & Baptist Memorial Health Care

**Contacts:** G. Scott Morris, MD, M.Div.; Christian Patrick, MD, PhD; Antony Sheehan, Hon.D.Sci., M.Phil., B.Ed. (Hons.), RN, Dip.HSM, MHSM, IHI Quality Improvement Fellow 2011-2012; Skip Steward, MBA; Mark Swanson, MD, MHCM, FAAP, FCCP, FCCM, FAIHQ, CHQM

**Clinic:**

- PGY1: 1 day of continuity clinic
- PGY2/3: 2 days of continuity clinic

The focus on Management of Health Systems in our residency program is to train leaders in primary care for the new millennium. Leadership training will begin during the resident’s first days at Baptist with an orientation that provides a solid foundation of our basic principles:

- Service Excellence
- Confidentiality/ HIPAA
- Pastoral Care
- Workplace Culture
- Safety & Quality Improvement
- Cultural Diversity
- Code of Conduct
- Policies/ Procedures

Also included during the first month will be in-depth training in our EMR and Competency/ Skills Testing. During that month and annually during their residency period, residents will focus on inpatient and outpatient quality issues and outcomes and gain a high-level understanding of Health System Management/ Population & Community Health from several of our top leaders. Those leaders include:

- Chief Executive Officer of the Church Health, Dr. Scott Morris
- President of the Church Health, IHI Fellow, Antony Sheehan
- System Chief Medical Officer, Dr. Mark Swanson
- System Director of Performance Improvement, Skip Steward
- Chief Medical Officer of our Flagship facility, BMH – Memphis, Dr. Chris Patrick

Throughout each year, residents will receive clinical site management mentoring by the highly experienced administrative team at the Church Health.

Residents will participate in many community outreach programs such as “Health Alliance Common Table” and “Healthy Shelby” that work to gain managerial experience in a less clinical setting while improving neighborhood and public health.

**Most uniquely, residents will have a block dedicated to Health System Management in each of the 3 years.**

That Curriculum will include training in the Baptist Management System and classes on Standardization called “Training within Industry”. This education will entail 2 -4 hours a week didactic session during each Health Systems
Education through the Church Health will proceed as below:

PGY 1 – Clinical Quality and Health Outcomes Measurement

1. **Goal** – Resident becomes familiar with the data, systems and processes to systematically measure the quality of care provided to the patients and to track patient health outcomes.

   **Objective**
   
   A. Completes Institute for Healthcare Improvement (IHI) Open School web based offerings online related to Quality Improvement.
   B. Demonstrates the ability to track quality of healthcare services provided by the healthcare system that will indicate the provider’s ability to deliver high-quality care or create long-term goals for patient to receive quality care.
   C. Measure success of clinical activities recognized by the healthcare industry as appropriate and necessary for patients.
   D. Demonstrates ability to measure provider’s performance compared to health system standards at the provider, healthcare services and health system level.
   E. Resident demonstrates knowledge of coding, documentation and billing practices.

2. **Goal** – Congregational Health Promoter (CHP) and Congregational Health Network (CHN) and Memphis Healthy Churches (MHC) programs offer church congregations in Memphis an opportunity to integrate Faith and Health in their daily activities. Residents will gain an understanding of the importance of role of each of the programs in the faith and health community. Resident will acquire knowledge to replicate programs.

   **Objective**
   
   A. Resident will complete programs offered by Church Health and Baptist Memorial Healthcare.
   B. Resident will shadow individuals well established in their role within the congregation as they offer opportunities integrating faith and health to their congregations.

3. **Goal** – Resident will understand value and outcomes of overarching community organizations such as Common Table Health Alliance, Memphis Healthy Shelby and their impact on population health.

   **Objective**
   
   A. Understands the importance of Triple Aim (IHI), Triple Aim - improving patient experience of care, improving the health of populations, and reducing the per capita cost of healthcare
   B. Attends regular meetings of organization accompanied by Executive Team members, participates in activities of organization related to Triple Aim (IHI) and other programs including but not limited to health equity and infant mortality

4. **Goal** – The Model for Healthy Living, a model of patient/member care created by the Church Health, places the patient/member in the center of the model and surrounds them with services offered by the Center intended to help them reach their highest level of wellness. The Resident will embrace the Model using aspects of the Model in caring for the patients/members.

   **Objective:**
   
   B. Attend Courses/classes at Wellness related to the Model.
Curricular Expectations

PGY 2 – Integrated Health and Serving the Underserved

1. Goal – To understand and adopt skills, knowledge and collaboration needed to serve the underserved, must complete eight session course offered by Church Health titled “Serving the Underserved”
   Objective
   A. Demonstrate in clinical practice skills and knowledge gained by attending “Serving the Underserved”
   B. Complete assigned reading list on Underserved/ Medically Challenged Populations
   C. Interview as assigned providers, administrators and others who work with underserved populations

2. Goal – To recognize benefit offered by treatment considered alternative or integrative medicine including but not limited to acupuncture or other alternative forms of medicine.
   Objective
   A. Shadow providers offering acupuncture or other alternative forms of medicine.
   B. Complete assigned reading list on Complementary/ Integrative medicine

3. Goal – To participate in a Replication Seminar offered by the CH. The seminar is a two day “how to” on replicating the clinic of the Church Health.
   A. Attend two day Replication seminar.
   B. Complete mock business plan for a replication clinic to be submitted for review including spending, financial strategy, budgeting, capital planning, per capita spending, contracting and compensation alignment.

PGY 3 – Triple Aim and Accountability throughout the Healthcare System

1. Goal – Resident will achieve clarity of mission as it aligns with the Triple Aim – improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care
   Objective
   A. Resident will identify populations to be served.
   B. Resident participates in improvement projects related to population health
   C. Resident demonstrates ways clinic and community are reducing the per capita cost of health care.

2. Goal – Resident will recognize importance of role of governance structures to ensure the health system achieves the desired aims, to promote and coordinate the necessary organizational changes and to ensure accountability throughout the health system.
   A. Resident will identify existing governance committee that provides direction and oversight for the healthcare system, services, or overall organizational objectives.
   B. Residents will identify governance committee that appropriately represents all stakeholders. Stakeholders may include patients and families, payers, local community health organizations, providers, local governments.

3. Goal – Providers are appropriately trained on the skills necessary to succeed in delivery model of the Center and to ensure there are sufficient numbers of provider leaders and champions to lead in transformation initiatives.
   Objective
Curricular Expectations

A. Resident completes in person, web based, or online options that ensure providers have the ability to establish and nurture partnerships with care team members and encourage effective teamwork and collaboration, while ensuring patients receive the care they need and prefer.

B. Resident serves/shadows a champion in an area designated through strategic planning.

Resident describes team based care recognizing different clinicians will assume principal responsibility for specific elements of a patient's care as the patient's needs dictate, while the team as a whole must ensure that all elements of care are coordinated for the patient's benefit.
Hospice and Palliative Care

1 Block Rotation (4 weeks) during R2 year
1 day/week continuity clinic at Church Health

Recommended References:
1. UNIPAC Hospice and Palliative Care Training for Physicians self-study program
2. Clinical Practice Guidelines for Quality Palliative Care by the National Consensus Project for Quality Palliative Care: [link]

Administrative Responsibilities for Hospice and Palliative Medicine Resident:
1. Complete evaluations on all assigned patients and consults.
2. Write orders.
3. Dictate admit, consult and progress notes.
4. Complete IPOSTs, DNR/DNI and comfort care orders with assistance of team nurses and/or attending physician.
   a. Communicate verbally with attending physician at the time of evaluation.
   b. Coordinate patient care with referring physicians and communicate any recommendations verbally to those physicians.
   c. Communicate with patient’s family as appropriate.
5. Electronically sign all dictated notes.
6. Complete daily administrative tasks for resident’s continuity practice.

Procedural Responsibilities:

** Attending is required to be present for all non-emergent procedures **
1. Ventilator withdrawal
2. Palliative sedation

Interpretive Responsibilities:
1. Determination of capacity for decision-making
2. Determination of surrogate decision-maker
3. Lab values related to Hospice and Palliative Care
4. Dementia screens:
   - [link]
   - [link]

Additional Resources and Tutorials:
1. American Academy of Hospice and Palliative Medicine: [link]
2. End-of-Life/Palliative Care Resources (one-page, peer-reviewed information summaries arranged by topic): [link]
3. End of Life/Palliative Education Resource Center: [link]
4. National Guideline Clearinghouse: [link]
5. Up-To-Date: [link]
6. The Cochrane Library: [link]
## Curricular Expectations

8. PDA tools: [http://www.aahpm.org/physresources/pda.html](http://www.aahpm.org/physresources/pda.html)

## Competency Goals:

### Patient and Family Care

<table>
<thead>
<tr>
<th>Competency</th>
<th>Sub-competency</th>
<th>Sample Behavior</th>
<th>Assessment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Gathers comprehensive and accurate information from all pertinent sources, including patient, family members, health care proxies, other health care providers, interdisciplinary team members and medical records</td>
<td>1.1.1. Obtains a comprehensive medical history and physical exam, including: Patient understanding of illness and prognosis Goals of care/advance care planning/proxy decision-making Detailed symptom history (including use of validated scales) Psychosocial and coping history including loss history Spiritual history Functional assessment Quality of life assessment Depression evaluation (including stressors and areas of major concern) Pharmacologic history including substance dependency or abuse Detailed neurological exam, including mental status exam</td>
<td>Suggests plan of care, based on available information and evaluation, in consultation with attending physician.</td>
<td>Attending physician assessment of resident.</td>
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<tr>
<td></td>
<td>1.1.2 Perform diagnostic workup; reviews primary source information and evaluation</td>
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<td></td>
<td>1.1.3 Utilizes information technology; accesses on-line evidence-based medicine resources; uses electronic repositories of information, and medical records</td>
<td>Operates electronic information resources in a familiar manner</td>
<td>Attending physician assessment of resident.</td>
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<tr>
<td></td>
<td>1.2 Synthesizes and applies information in the clinical setting</td>
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<tr>
<td></td>
<td>1.2.1 Develops a prioritized differential diagnosis and problem list</td>
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<td>Attending physician assessment of resident. Chart/record review</td>
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<tr>
<td></td>
<td>1.2.2 Develops recommendations based on patient and family values</td>
<td>Integrates patient’s and/or family's values into written goals of care and treatment plan</td>
<td>Family assessment of resident.</td>
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<tr>
<td></td>
<td>1.2.3 Routinely obtains additional clinical information (from other physicians, nurses, pharmacists, social workers, case managers,</td>
<td>Collects information from other clinicians when needed</td>
<td>Team evaluation</td>
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<tr>
<td>Competency</td>
<td>Sub-competency</td>
<td>Sample Behavior</td>
<td>Assessment Method</td>
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<tr>
<td>1.3 Demonstrates use of the interdisciplinary approach to develop a care plan that optimizes patient and family goals and reduces suffering</td>
<td>chaplains, respiratory therapists) when appropriate</td>
<td></td>
<td>Team evaluation</td>
</tr>
<tr>
<td>1.4 Assesses and manages patients with the full spectrum of advanced, progressive, life-threatening conditions, including common cancers, common non-cancer diagnoses, chronic diseases, and emergencies</td>
<td></td>
<td></td>
<td>Attending physician assessment of resident</td>
</tr>
<tr>
<td>1.5 Manages physical symptoms, psychological issues, social stressors, and spiritual aspects of the patient and family</td>
<td>1.5.1 Assesses pain and non-pain symptoms</td>
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<td>Team evaluation</td>
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<td></td>
<td>1.5.2 Uses opioid and non-opioid pharmacologic options</td>
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<td>Team evaluation</td>
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<tr>
<td></td>
<td>1.5.3 Uses non-pharmacologic symptom interventions</td>
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<td>Team evaluation</td>
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<td></td>
<td>1.5.4 Manages neuropsychiatric disorders</td>
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<td>Team evaluation</td>
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<td></td>
<td>1.5.5 Manages physical symptoms and psychosocial and spiritual distress in the patient and family</td>
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<td>Team evaluation</td>
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<td>1.5.6 Re-assesses symptoms frequently, and makes therapeutic adjustments as needed</td>
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<td>Team evaluation</td>
</tr>
<tr>
<td>1.6 Provides care to patients and families that reflects unique characteristics of different settings along the palliative care spectrum</td>
<td>1.6.1 Performs palliative care assessment and management for the home visit, nursing home visit, inpatient hospice unit visit, outpatient clinic visit, and hospital patient visit</td>
<td></td>
<td>Team evaluation</td>
</tr>
<tr>
<td></td>
<td>1.6.2 Delivers timely and accurate information and addresses barriers to patient and family access to palliative care in multiple settings</td>
<td></td>
<td>Team evaluation Pt/Family assessment of resident.</td>
</tr>
<tr>
<td>Competency</td>
<td>Sub-competency</td>
<td>Sample Behavior</td>
<td>Assessment Method</td>
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<tr>
<td>1.6.3 Works with families in an interdisciplinary manner to formulate discharge plans for patients and families</td>
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<td></td>
<td>Team evaluation Pt/Family assessment of resident.</td>
</tr>
<tr>
<td>1.7 Bases care on patient’s past history and patient and family preferences and goals of care, prognostic information, evidence, clinical experience and judgment</td>
<td>1.7.1 Demonstrates a patient-family centered approach to care</td>
<td>Produces a patient and family-centered plan of care</td>
<td>Team evaluation</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Family assessment of resident.</td>
</tr>
<tr>
<td></td>
<td>1.7.2 Makes recommendations to consulting physician(s) as appropriate</td>
<td>Formulates adequate palliative care recommendations; follows appropriate consult etiquette</td>
<td>Attending physician assessment of resident.</td>
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<td></td>
<td>Consultant assessment of resident.</td>
</tr>
<tr>
<td>1.8 Demonstrates the ability to respond to suffering through addressing sources of medical and psychosocial/spiritual distress, bearing with the patient’s and family’s suffering and distress, and remaining a presence, as desired by the patient and family</td>
<td></td>
<td></td>
<td>Team evaluation Pt/Family assessment of resident.</td>
</tr>
<tr>
<td>1.9 Demonstrates care that shows respectful attention to age/developmental stage, gender, sexual orientation, culture, religion/spirituality, as well as family interactions and disability</td>
<td></td>
<td>Recognizes and respects patient’s and family’s uniqueness</td>
<td>Team evaluation Pt/Family assessment of resident.</td>
</tr>
<tr>
<td>1.10 Seeks to maximize patients’ level of function, and quality of life for patients and families</td>
<td>1.10.1 Evaluates functional status over time</td>
<td>Uses appropriate tools to measure functional status</td>
<td>Team evaluation</td>
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<td>Chart/record review</td>
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<tr>
<td></td>
<td>1.10.2 Evaluates quality of life over time</td>
<td>Documents quality of life in medical chart</td>
<td>Team evaluation</td>
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<td>Chart/record review</td>
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<tr>
<td>1.10.3</td>
<td>Provides expertise in maximizing patient's level of function and quality of life</td>
<td>Refers to appropriate services</td>
<td>Team evaluation</td>
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<td>Chart/record review</td>
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<tr>
<td>1.10.4</td>
<td>Seeks to preserve opportunities for individual and family life in the context of life-threatening illness</td>
<td></td>
<td>Pt/Family assessment of resident.</td>
</tr>
<tr>
<td>1.10.5</td>
<td>Recognizes the potential value to patients and their family members of completing personal affairs/unfinished business</td>
<td>Identifies and facilitates opportunities to resolve unfinished issues</td>
<td>Team evaluation</td>
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<tr>
<td>1.10.6</td>
<td>Effectively manages physical symptoms and psychosocial and spiritual distress in the patient and family</td>
<td></td>
<td>Team evaluation</td>
</tr>
<tr>
<td>1.11</td>
<td>Provides patient and family education</td>
<td>1.11.1 Educates families in maintaining and improving level of function to maximize quality of life</td>
<td>Team evaluation</td>
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<tr>
<td></td>
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<td>1.11.2 Explains palliative care services, recommendations and latest developments to patients and families</td>
<td>Team evaluation</td>
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<tr>
<td></td>
<td></td>
<td>1.11.3 Educates patient and family about disease trajectory and how and when to access palliation in future</td>
<td>Team evaluation</td>
</tr>
<tr>
<td>1.12</td>
<td>Recognizes signs and symptoms of impending death and cares for the imminently dying patient and their family members</td>
<td>1.12.1 Effectively prepares family, other health care professionals, and caregivers for the patient’s death</td>
<td>Team evaluation; Pt/Family assessment of resident.</td>
</tr>
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<td>1.12.2 Provides assessment and symptom management for the imminently dying patient</td>
<td>Team evaluation</td>
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<td>1.12.3 Demonstrates compassion, expresses condolences, explores family questions, and provides information as desired by the family</td>
<td>Attending physician assessment of resident.</td>
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<td>Family assessment of resident.</td>
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<tr>
<td>1.13</td>
<td>Provides treatment to the bereaved</td>
<td>1.13.2 Involves interdisciplinary team members in interacting with the bereaved</td>
<td>Team evaluation</td>
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<td>Team evaluation</td>
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### Patient and Family Care

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<tr>
<th>Competency</th>
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<th>Assessment Method</th>
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<tbody>
<tr>
<td>1.13.3 Refers family members to bereavement programs</td>
<td></td>
<td>Knows available community resources</td>
<td>Team evaluation</td>
</tr>
<tr>
<td>1.14 Refers patients and family members to other health care professionals to assess, treat and manage patient and family care issues outside the scope of palliative care practice and collaborates effectively with them</td>
<td>1.14.1 Recognizes the need for collaboration with clinicians providing disease-modifying treatment</td>
<td></td>
<td>Attending physician assessment of resident. Resident self-assessment Consultant assessment of resident.</td>
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<tr>
<td>1.14.2 Collaborates with and makes referrals to pediatricians with expertise relevant to the care of children with advanced, progressive, and life-threatening illness</td>
<td></td>
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<td>Attending physician assessment of resident. Consultant assessment of resident.</td>
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<tr>
<td>1.14.3 Accesses specialized pediatric and geriatric palliative care resources appropriately</td>
<td></td>
<td>Integrates mental health clinicians’ recommendations into patients’ plans of care</td>
<td>Attending physician assessment of resident. Consultant assessment of resident.</td>
</tr>
<tr>
<td>1.14.4 Collaborates with other mental health clinicians to meet the needs of patients with major mental health issues</td>
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<td>Attending physician assessment of resident. Consultant assessment of resident.</td>
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### Medical Knowledge:

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<tbody>
<tr>
<td>2.1 Describes the scope and practice of hospice and palliative medicine, including: Domains of hospice and palliative care including role of palliative care in co-management of patients with potentially life-limiting illness at all stages of disease and in the presence of restorative, curative, and life-prolonging goals</td>
<td>Identifies palliative care domains that could be addressed for any patient with potentially life-limiting illness at all stages of disease and in the setting of all other appropriate therapies Demonstrates appropriate preparation for home visit Prepares appropriate discharge plan for complex inpatients, carries out or assures all related tasks, and assures good follow-up</td>
<td></td>
<td>Attending physician assessment of resident Chart/record review Team evaluation</td>
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## Medical Knowledge:

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<tbody>
<tr>
<td>Elements of patient assessment and management across different hospice and palliative care settings, including home visit, nursing home visit, inpatient hospice unit visit, outpatient clinic visit, and in hospital patient visit.</td>
<td></td>
<td>Assesses compliance in the ambulatory setting and uses home services to promote and further assess compliance. Describes essential elements and eligibility criteria for hospice. Correctly evaluates patients for their hospice eligibility and appropriateness for a variety of hospice levels of care. In evaluating patients and families for hospice, identifies psychological, social, economic, and other barriers to accessing hospice.</td>
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<tr>
<td>The Medicare/Medicaid Hospice Benefit, including essential elements of the program, eligibility, and key regulations for all levels of hospice care</td>
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<td>Barriers faced by patients and families in accessing hospice and palliative care services</td>
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<tr>
<td>2.2 Recognizes the role of the interdisciplinary team (IDT) in hospice and palliative care</td>
<td>2.2.1 Describes the role of the palliative care physician in the interdisciplinary team</td>
<td>Identifies the roles performed by a physician on a particular team and evaluates this in terms of the potential range of roles that physicians can play.</td>
<td>Attending physician assessment of resident Team evaluation</td>
</tr>
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<td></td>
<td>2.2.2 Identifies the various members of the interdisciplinary team and their roles and responsibilities</td>
<td>Describes the actual role of various clinicians on a team and evaluates their behaviors in terms of the potential roles they can play.</td>
<td>Attending physician assessment of resident Team evaluation</td>
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<td></td>
<td>2.2.3 Recognizes how and when to collaborate with other allied health professionals, such as nutritionists, physical therapists, respiratory therapists, occupational therapists, speech therapists, and case managers</td>
<td>Demonstrates appropriate referral to allied health professionals in formulating and carrying out a care plan.</td>
<td>Attending physician assessment of resident Team evaluation</td>
</tr>
<tr>
<td></td>
<td>2.2.4 Describes concepts of team process and recognizes psychosocial and organizational elements that promote or hinder</td>
<td>Describes team processes evident in a team meeting.</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>successful interdisciplinary team function</td>
<td>2.3 Describes how to assess and communicate prognosis</td>
<td>In evaluating patients, identifies key elements (history, physical examination, and laboratory) that are useful in prognostication.</td>
<td>Attending physician assessment of resident</td>
</tr>
<tr>
<td>2.3.1 Identifies what elements of the patient’s history and physical examination are critical to formulating prognosis for a given patient</td>
<td>2.3.2 Describes common chronic illnesses with prognostic factors, expected natural course and trajectories, common treatments, and complications</td>
<td>For cancer, heart failure, dementia, and anoxic or traumatic brain injury, describes the key prognostic factors for severe disability or death and formulates a prognosis For common cancers at typically incurable stages, describes the mean survival for treated and untreated disease Describes major modalities of treatment for metastatic cancer, congestive heart failure, chronic obstructive lung disease, ALS, and dementias, and is able to apply this knowledge to outline care options for specific clinical cases Recognizes common side effects of chemotherapy agents and biologicals, and is able to describe these to patients and family members Describes key clinical features and is able to recognize major and urgent cancer complications, such as cord compression, superior vena cava syndrome, hypercalcemia, hyponatremia</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.3.3</td>
<td>Describes effective strategies to communicate prognostic information to patients, families and health care providers</td>
<td>Uses clinical data to construct a prognosis, and then communicates this prognosis to a patient</td>
<td>Team evaluation</td>
</tr>
<tr>
<td>2.4</td>
<td>Recognizes the presentation and management of common cancers, including their epidemiology, evaluation, prognosis, treatment, patterns of advanced or metastatic disease, emergencies, complications, associated symptoms, and symptomatic treatments</td>
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<tr>
<td>2.4.1</td>
<td>Identifies common diagnostic and treatment methods in the initial evaluation and ongoing management of cancer</td>
<td>In a variety of clinical situations in which metastatic disease is suspected, describes typical diagnostic efforts to confirm the diagnosis.</td>
<td>Attending physician assessment of resident</td>
</tr>
<tr>
<td>2.4.2</td>
<td>Identifies common elements in prognostication for solid tumors and hematological malignancies at various stages, including the natural history of untreated cancers</td>
<td>For common cancers at various stages, distinguishes potentially curable from incurable disease, and describes the prognosis for treated and untreated disease Uses prognostic information appropriately in discussing diagnostic and treatment options with patients and families.</td>
<td>Attending physician assessment of resident</td>
</tr>
<tr>
<td>2.4.3</td>
<td>Describes patterns of advanced disease, associated symptoms, and symptomatic treatments for common cancers</td>
<td>Demonstrates familiarity with the common patterns of metastatic disease and associated symptoms for advanced ovarian cancer Demonstrates familiarity with common patterns of spread of common metastatic cancers, such as colonic carcinoma For common symptoms of advanced cancer, formulates a differential diagnosis of the etiology and of appropriate diagnostic</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.4.4  Describes the presentation and management of common complications of malignancy, i.e. hypercalcemia and brain metastases, and emergencies, i.e. seizures and hemorrhage</td>
<td>For a patient with metastatic breast cancer and new onset of severe back pain, demonstrates an awareness of the possibility of epidural cord compression, its diagnosis, and early treatment</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.5.1 Identifies markers of advanced disease in common non-cancer life-threatening conditions, such as congestive heart failure, chronic obstructive pulmonary disease, and dementia</td>
<td>In analyzing the presenting clinical data for patients with a variety of non-cancer life-threatening conditions, formulates a prognosis and eligibility for hospice</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.5.2 Describes patterns of advanced disease, associated symptoms, (i.e. dyspnea for congestive heart failure and dysphagia for dementia), and symptomatic treatments for common non-cancer life-threatening conditions</td>
<td>Identifies common symptoms of advanced gastric cancer and describes symptomatic treatment. Provides a comprehensive evaluation for the symptoms associated with hypercalcemia and prescribes appropriate management</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.5.3 Describes the presentation and management of common complications of non-cancer life-threatening conditions, i.e. pulmonary edema and psychosis, and emergencies, i.e. myocardial infarction</td>
<td>Provides a comprehensive evaluation of advanced chronic lung disease, and prescribes or suggests appropriate management, including preparation for dealing with likely signs of</td>
<td>Attending physician assessment of resident</td>
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<td>coronary artery disease and stroke for cerebrovascular disease</td>
<td>deterioration or the need for emergency care</td>
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<tr>
<td>2.6 Explains principles of assessing pain and other common non-pain symptoms</td>
<td>2.6.1 Describes the concept of “total pain”</td>
<td>Provides a comprehensive analysis of patients with pain and identifies the physical, psychosocial, and spiritual components of distress</td>
<td>Attending physician assessment of resident</td>
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<td></td>
<td>2.6.2 Explains the relevant basic science, pathophysiology, associated symptoms and signs, and diagnostic options useful in differentiating among different etiologies of pain and non-pain symptoms</td>
<td>Evaluates patients with pain and other non-pain symptoms, and differentiates among possible etiologies. Describes common features of pain and non-pain symptoms that suggest particular etiologies, and distinguishes and identifies useful diagnostic options to clarify the etiology Describes the basic science and pathophysiology of common pain and non-pain symptoms</td>
<td>Attending physician assessment of resident</td>
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<td>2.6.3 Describes a thorough assessment and functional status of pain and other symptoms, including the use of appropriate diagnostic methods and symptom measurement tools</td>
<td>In evaluating patients, demonstrates an ability to assess and appropriately manage pain and other symptoms</td>
<td>Attending physician assessment of resident</td>
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<td>2.6.4 Names common patient, family, health care professional, and health care system barriers to the effective treatment of symptoms</td>
<td>In evaluating patients, identifies and addresses common barriers to effective treatment, such as fears of addiction and tolerance, difficulties with adhering to complicated medication schedules, discomfort with intimate bodily contact or exposure</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.7 Describes the use of opioids in pain and non-</td>
<td>2.7.1 Lists the indications, clinical pharmacology, alternate routes,</td>
<td>Demonstrates an ability to correctly prescribe opioids for pain and non-pain</td>
<td>Attending physician assessment of resident</td>
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<td>pain symptom management</td>
<td>equianalgesic conversions, appropriate titration, toxicities, and management of common side effects for opioids</td>
<td>symptom management in a variety of settings, including choice of route, dosage, intervals, steps in titration, and prevention and management of side effects and toxicity</td>
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<tr>
<td>2.7.2 Describes appropriate opioid prescribing, monitoring of treatment outcomes, and toxicity management in chronic, urgent and emergency pain conditions.</td>
<td>For a patient with poorly controlled pain on acetaminophen, chooses the appropriate additional pain medication and dosage, reflecting an awareness of the etiology of the pain, it's severity, risks of toxicity, and appropriate monitoring and follow-up For a patient on chronic oral methadone for abdominal and back pain associated with metastatic pancreatic cancer who now is unable to take pills because of severe nausea and vomiting, prescribes an appropriate regimen of morphine or hydromorphone, administered via patient-controlled analgesia</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.7.3 Describes appropriate opioid prescribing in different clinical care settings: home, residential hospice, hospital, long-term care facility</td>
<td>For a patient on a complex analgesic regimen and being discharged to a nursing home from a hospital, prescribes an appropriate analgesic regimen that is suitable for this new setting In choosing an opioid regimen for a patient in hospice, prescribes medications in a manner that demonstrates awareness of such issues as cost, convenience, availability, and compliance</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.7.4 Describes the concepts of addiction, pseudo-addiction, dependence and tolerance, and describes</td>
<td>For a patient in recovery from opioid abuse and now with pain from widely metastatic bony metastasis, counsels</td>
<td>Attending physician assessment of resident</td>
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<td>their significance in pain management, as well as approaches to managing pain in patients with current or prior substance abuse</td>
<td>the patient about the risks of dependence and tolerance, the importance of good analgesia and a regimen that allows for careful monitoring while minimizing the risk of addiction</td>
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<td></td>
<td>2.7.5 Explains the legal and regulatory issues surrounding opioid prescribing</td>
<td>Writes opioid prescriptions that reflect an awareness of pertinent legal and regulatory issues, including the amount prescribed, managing increases in dosage between prescriptions, and the need for written prescriptions for refills</td>
<td>Attending physician assessment of resident</td>
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<td></td>
<td>2.8 Describes the use of non-opioid analgesics, adjuvant analgesics, and other pharmacologic approaches to the management of both pain and non-pain symptoms</td>
<td>2.8.1 Identifies the indications, clinical pharmacology, alternate routes, appropriate titration, toxicities, and management of common side effects for: acetaminophen, aspirin, NSAIDs, corticosteroids, anticonvulsants, antidepressants, and local anesthetics used in the treatment of pain and non-pain symptoms. Recognizes neuropathic pain and correctly prescribes anticonvulsants or antidepressants Correctly describes the use of non-opioid analgesics, their common toxicities, contraindications, and how they are prescribed In prescribing corticosteroids at low doses for pain, identifies additional beneficial and harmful effects</td>
<td>Attending physician assessment of resident</td>
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<td>2.9 Describes pharmacologic approaches to the management of common non-pain symptoms</td>
<td>2.9.1 Describes use of common agents used to treat dyspnea, nausea, vomiting, diarrhea, constipation, anxiety, depression, fatigue, pruritus, confusion, agitation, and other common problems in palliative care practice Describes a clinical approach to managing nausea and vomiting refractory to common agents, including the utility of various diagnostic efforts In evaluating patients with delirium, provides a comprehensive differential diagnosis based on history, physical examination, and laboratory tests, and correctly prescribes treatments aimed at the</td>
<td>Attending physician assessment of resident</td>
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<td>1.8.1.2 Identifies the etiology of the delirium or at the symptom, including both pharmacological and nonpharmacological treatments</td>
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<td>2.9.2 Identifies the indications, clinical pharmacology, alternate routes, appropriate titration, toxicities, and management of common side effects for: opioids, anxiolytics, antihistamines, laxatives, psychostimulants, corticosteroids, antidepressants, antihistamines, neuroleptics, sedatives and other common agents used in palliative care practice</td>
<td>Prescribes a satisfactory bowel regimen whenever prescribing opioids</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.9.2 Identifies the indications, clinical pharmacology, alternate routes, appropriate titration, toxicities, and management of common side effects for: opioids, anxiolytics, antihistamines, laxatives, psychostimulants, corticosteroids, antidepressants, antihistamines, neuroleptics, sedatives and other common agents used in palliative care practice</td>
<td>Prescribes benzodiazepines with an awareness of their half-lives, appropriate titration, and common toxicities</td>
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<tr>
<td>2.9.2 Identifies the indications, clinical pharmacology, alternate routes, appropriate titration, toxicities, and management of common side effects for: opioids, anxiolytics, antihistamines, laxatives, psychostimulants, corticosteroids, antidepressants, antihistamines, neuroleptics, sedatives and other common agents used in palliative care practice</td>
<td>Appropriately suggests neuroleptics for delirium and agitation, and is able to provide a rationale for use of particular agents</td>
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<tr>
<td>2.10 Describes the use of non-pharmacologic approaches to the management of pain and non-pain symptoms</td>
<td>2.10.1 Identifies indications, toxicities, and appropriate referral for interventional pain management procedures, as well as surgical procedures commonly used for pain and non-pain symptom management</td>
<td>In describing the diagnosis and treatment of pancreatic cancer, explains the role of celiac plexus block, complications, and usual outcomes</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.10 Describes the use of non-pharmacologic approaches to the management of pain and non-pain symptoms</td>
<td>2.10.2 Identifies indications, toxicities, management of common side effects, and appropriate referral for radiation therapy</td>
<td>Suggests the use of hypofractionated radiation therapy for selected patients with metastatic bone cancer</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.10 Describes the use of non-pharmacologic approaches to the management of pain and non-pain symptoms</td>
<td>2.10.3 Identifies indications, toxicities, and appropriate referral for commonly used complementary and alternative therapies, i.e. acupuncture, aromatherapy, guided imagery</td>
<td>For appropriately selected patients, explains and suggests relaxation exercises, and makes appropriate referrals</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.10 Describes the use of non-pharmacologic approaches to the management of pain and non-pain symptoms</td>
<td>2.10.4 Explains the role of allied health professions in pain and non-pain symptom management, such as speech, physical,</td>
<td>For patients with ALS at various stages of progression, is familiar with and able to prescribe appropriate use of speech,</td>
<td>Attending physician assessment of resident</td>
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### Curricular Expectations

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<td><strong>Competency</strong></td>
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<td>respiratory, and occupational therapy</td>
<td>physical, respiratory, and occupational therapy</td>
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<tr>
<td>2.11 Describes the etiology, pathology, diagnosis, and management of common neuropsychiatric disorders encountered in palliative care practice, such as depression, delirium, seizures, and brain injury</td>
<td>2.11.1 Recognizes how to evaluate, and treat common neuropsychiatric disorders</td>
</tr>
<tr>
<td>2.11.2 Describes how to refer appropriately to neurological and mental health professionals</td>
<td>2.11.3 Describes the indications, contraindications, pharmacology, appropriate prescribing practice, and side-effects of common psychiatric medications</td>
</tr>
<tr>
<td>2.11.4 Recognizes the diagnostic criteria and management issues of brain death, persistent vegetative state, and minimally conscious state</td>
<td>Lists the diagnostic criteria for brain death and persistent vegetative state</td>
</tr>
<tr>
<td>2.12 Recognizes common psychological stressors and disorders experienced by patients and families facing life-threatening conditions, and describes appropriate clinical assessment and management.</td>
<td>2.12.1 Recognizes psychological distress</td>
</tr>
<tr>
<td>2.12.2 Describes concepts of coping styles, psychological defenses, and developmental stages relevant to the evaluation</td>
<td>Lists and defines coping styles and psychological defenses</td>
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<tr>
<td>Competency</td>
<td>Sub-competency</td>
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<tr>
<td></td>
<td>and management of psychological distress</td>
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<tr>
<td>2.12.3</td>
<td>Describes how to provide basic supportive counseling and to strengthen coping skills</td>
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<tr>
<td>2.12.4</td>
<td>Recognizes the needs of minor children when an adult parent or close relative is seriously ill or dying, and provides appropriate basic counseling or referral</td>
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<td></td>
<td>Routinely evaluates needs of siblings and parents when children are seriously ill</td>
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<tr>
<td>2.12.5</td>
<td>Recognizes the needs of parents and siblings of children who are seriously ill or dying and provides appropriate basic counseling or referral</td>
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<td>Demonstrates effective basic counseling and appropriate referral for siblings and parents</td>
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<tr>
<td>2.12.6</td>
<td>Explains appropriate utilization of consultation with specialists in psychosocial assessment and management</td>
</tr>
<tr>
<td>2.13</td>
<td>Recognizes common social problems experienced by patients and families facing life-threatening conditions and describes appropriate clinical assessment and management</td>
</tr>
<tr>
<td>2.13.1</td>
<td>Able to assess, counsel, support, and make appropriate referrals to alleviate the burden of caregiving</td>
</tr>
<tr>
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<td>Routinely assesses for level of caregiver burden</td>
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<tr>
<td>2.13.2</td>
<td>Able to assess, provide support, and make appropriate referral around fiscal issues, insurance coverage, and legal concerns</td>
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<td>Routinely assesses for distress around financial insurance, and legal concerns</td>
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## Medical Knowledge:

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<th>Competency</th>
<th>Sub-competency</th>
<th>Sample Behavior</th>
<th>Assessment Method</th>
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<tbody>
<tr>
<td>2.14</td>
<td>Recognizes common experiences of distress around spiritual, religious, and existential issues for patients and families facing life-threatening conditions, and describes elements of appropriate clinical assessment and management</td>
<td>2.14.1 Describes the role of hope, despair, meaning, and transcendence in the context of severe and chronic illness</td>
<td>Team evaluation</td>
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<td>Defines hope, despair, meaning, and transcendence in a practical sense that promotes understanding for patients, families, and staff in this setting</td>
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<td>2.14.2</td>
<td>Describes how to perform a basic spiritual/existential/religious evaluation</td>
<td>Explains an organized approach to covering basic elements of a spiritual/existential/religious history</td>
<td>Team evaluation</td>
</tr>
<tr>
<td>2.14.3</td>
<td>Describes how to provide basic spiritual counseling</td>
<td>Defines basic principles of spiritual counseling and common scenarios where counseling could be of benefit</td>
<td>Team evaluation</td>
</tr>
<tr>
<td>2.14.4</td>
<td>Identifies the indications for referral to chaplaincy or other spiritual counselors and resources</td>
<td>Lists indications for referral to chaplaincy or other spiritual resources</td>
<td>Team evaluation</td>
</tr>
<tr>
<td>2.14.5</td>
<td>Knows the developmental processes, tasks, and variations of life completion and life closure</td>
<td>Describes common tasks of life closure for dying patients</td>
<td>Team evaluation</td>
</tr>
<tr>
<td>2.14.6</td>
<td>Describes processes for facilitating growth and development in the context of advanced illness</td>
<td>Names strategies to facilitate growth and development for a patient with advanced illness</td>
<td>Team evaluation</td>
</tr>
<tr>
<td>2.15</td>
<td>Able to recognize, evaluate, and support diverse cultural values and customs with regard to information sharing, decision making, expression and treatment of physical and emotional distress, and preferences for sites of care and death.</td>
<td>2.15.1 Recognizes major contributions from non-medical disciplines, such as sociology, anthropology, and health psychology, in understanding and managing the patient’s and family’s experience of serious and life-threatening illness</td>
<td>Team evaluation</td>
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<td></td>
<td>Assesses patient and family cultural values and customs in regard to information sharing, decision-making, expression and treatment of physical and emotional distress, and preferences for sites of care and death</td>
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### Curricular Expectations

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<th>Competency</th>
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<td>Medical Knowledge:</td>
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<tr>
<td>2.16 Recognizes the components of management for the syndrome of imminent</td>
<td>2.16.1 Identifies common symptoms, signs, complications and variations in the normal dying process and their management</td>
<td>Demonstrates respect for and effort to honor diverse cultural values and customs</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>death</td>
<td>2.16.2 Describes strategies to communicate with patient and family about the dying process and to provide support</td>
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<tr>
<td>2.17 Recognizes the elements of appropriate care of the patient and family</td>
<td>2.17.1 Describes appropriate and sensitive pronouncement of death</td>
<td>Identifies approaches for communicating with a patient and family about the dying process</td>
<td>Attending physician assessment of resident</td>
</tr>
<tr>
<td>at the time of death and immediately thereafter</td>
<td>2.17.2 Identifies the standard procedural components and psychosocial elements of post-death care</td>
<td>Explains a step-wise process for death pronouncement, including personal preparation, patient assessment, family notification, and documentation</td>
<td>Attending physician assessment of resident</td>
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<td>2.17.3 Recognizes the potential importance and existence of post-death rituals and how to facilitate them</td>
<td>Routinely elicits and facilitates post-death rituals of importance to patients and families</td>
<td>Team evaluation</td>
</tr>
<tr>
<td>2.18 Describes the basic science, epidemiology, clinical features, natural</td>
<td>2.18.1 Demonstrates knowledge of normal grief and elements of bereavement follow-up, including assessment, treatment, and referral options for bereaved family members</td>
<td>Defines normal grief; lists elements of bereavement assessment; identifies approaches to bereavement treatment; explains local referral options for bereavement counseling</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>course, stages, and management options for normal and pathologic grief</td>
<td>2.18.2 Recognizes the risk factors, diagnostic features, epidemiology, and</td>
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<tr>
<td>management of depression and complicated grief</td>
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<td>depression associated with bereavement</td>
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<td>Identify management strategies for complicated grief and depression associated with bereavement</td>
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<td>2.18.3. Appreciates risk of suicide in the bereaved and carries out initial assessment for suicide risk</td>
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<td>Attending physician assessment of resident</td>
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<tr>
<td>2.19 Describes common issues in the palliative care management of pediatric and geriatric patients and their families that differ from caring for adult patients, in regard to physiology, vulnerabilities, and developmental stages</td>
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<tr>
<td>2.19.1 Describes the epidemiology of pediatric life-threatening conditions</td>
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<td>Names common causes of death for infants, children, and adolescents and the age ranges for these categories</td>
<td>Attending physician assessment of resident</td>
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<td>Discusses the difficulty of prognostication in the setting of rare syndromes and other congenital abnormalities in childhood and its relevance to clinical care</td>
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<td>2.19.2 Appreciates developmental perspectives on illness, grief, and loss</td>
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<td>Explains common age-specific perspectives for patients and family members, as applied to illness, loss, and grief</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td>2.19.3 Describes pharmacologic principles applicable to the management of symptoms in infants, children, and adolescents</td>
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<td>Explains weight-based dosing approach for medications in pediatric patients. Recognizes the emphasis on preventing and managing procedure-related pain in pediatrics Names physiologic characteristics of neonates that may affect opioid pharmacology</td>
<td>Attending physician assessment of resident</td>
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<thead>
<tr>
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<th>Assessment Method</th>
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<tr>
<td>2.20 Describes ethical and legal issues in palliative and end-of-life care and their clinical management</td>
<td>2.20.1 Discusses ethical principles and frameworks for addressing clinical issues</td>
<td>Explains common ethical principles and their application in palliative medicine</td>
<td>Attending physician assessment of resident</td>
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<td>Applies ethical principles to given ethical dilemma</td>
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<td></td>
<td>2.20.2 Describes federal, state, and local laws and practices that impact on palliative care practice</td>
<td>Discusses federal, state, and local laws regarding such issues as advance directives, controlled substance regulation, management of resuscitation status, limits of doctor-patient relationship, decision-making capacity and consent, and management of life-sustaining therapy</td>
<td>Attending physician assessment of resident</td>
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<td>Team evaluation</td>
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<td></td>
<td>2.20.3 Consults clinical ethicist appropriately</td>
<td>Explains local procedure for ethics consultation; identifies appropriate scenarios for ethics involvement</td>
<td>Attending physician assessment of resident</td>
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<tr>
<td></td>
<td>2.20.4 Describes professional and institutional ethical policies relevant to palliative care practice</td>
<td>Explains professional and institutional ethical policies commonly applied to palliative care practice, such as limiting life-sustaining therapies, use of advance directives, decision-making capacity</td>
<td>Attending physician assessment of resident</td>
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</tbody>
</table>
BMH/CH Family Medicine Infectious Disease Rotation (ID)

Contacts:
Regina Neal, CH/BMH Residency Coordinator
Email: Regina.Neal@BMHCC.org
Phone: (901) 226-1358

Kent Alan Lee, MA. MD. FAAFP., Associate Program Director
Email: Kent.Lee@bmg.md
Phone: (479) 462-3259

Infectious Disease:

PGY 1: 2 days/week at Church Health Continuity Clinic
Work with Specialist in Office and on Inpatient consults

Goals:
To demonstrate competence appropriate for a general internist in the diagnosis and management of both inpatient and outpatient infectious diseases.

Objectives:
By the end of the Infectious Diseases Subspecialty experience; PGY 3 residents are expected to expand and cultivate skills and knowledge learned during previous training and to achieve the following objectives based on the six general competencies. The resident should attain Milestone Equivalent Level 3.5 on end-of-rotation evaluation.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Required Skill(s)</th>
<th>Teaching Method(s)</th>
<th>Formative Evaluation Method(s)</th>
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</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>SPECIALTY SPECIFIC OBJECTIVES</td>
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<tr>
<td></td>
<td>Evaluate and manage common infectious disease problems of adults in the hospital setting: Rational Use of Antimicrobial Agents Prevention and treatment of Central Line Infections</td>
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<tr>
<td></td>
<td>• Febrile Neutropenia</td>
<td>ID Team Attending Rounds</td>
<td>Direct Feedback &amp; Mini-CEX</td>
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<tr>
<td></td>
<td>• Nosocomial and Community Acquired Pneumonia</td>
<td>ID Clinical Conference</td>
<td>Praise/Concern Cards</td>
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<tr>
<td></td>
<td>• Cellulitis</td>
<td>Reading Lists</td>
<td>End of Rotation Evaluation</td>
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<tr>
<td></td>
<td>• Chronic Wound Infections</td>
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<td>• Endocarditis</td>
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<td>• Infections in Solid Organ Transplant Patients</td>
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<td>• Multi-drug Resistant Organisms such as MRSA and VRE</td>
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<td>• Sepsis Syndrome</td>
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<td>• Meningitis</td>
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<td>• FUO</td>
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<tr>
<td>Curricular Expectations</td>
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<tr>
<td><strong>Apply the principles of HIV/AIDS treatment:</strong></td>
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<tr>
<td>- Diagnosis of HIV</td>
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<td>- Initial Evaluation</td>
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<td>- Selection of Antiretroviral Agents</td>
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<td>- Prevention and Treatment of Opportunistic Infections</td>
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<td><strong>ID Team Attending Rounds</strong></td>
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<td><strong>Reading Lists</strong></td>
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<tr>
<td><strong>Core Curriculum Conference</strong></td>
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<td><strong>Direct Feed-back &amp; Mini-CEX</strong></td>
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<td><strong>End-of-Rotation Evaluation</strong></td>
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<tr>
<td><strong>Describe the basic principles of hospital epidemiology:</strong></td>
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<tr>
<td>- Hand Hygiene</td>
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<td>- Isolation Guidelines</td>
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<td><strong>End-of-Rotation Evaluation</strong></td>
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<tr>
<td><strong>Evaluate and manage the common outpatient infectious disease problems of adults:</strong></td>
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<td>- STDs</td>
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<td>- Diarrhea</td>
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<td>- Rashes</td>
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<td><strong>End-of-Rotation Evaluation</strong></td>
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<td><strong>Describe emerging Infectious Diseases:</strong></td>
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<td>- West Nile Virus</td>
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<td>- Bioterrorism</td>
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<td><strong>ID Team Attending Rounds</strong></td>
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<td><strong>End-of-Rotation Evaluation</strong></td>
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<tr>
<td><strong>Develop expertise in patient care and the medical knowledge base required to manage the following aspects of Infectious diseases:</strong></td>
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<td>- Febrile patients presenting with rash or FUO</td>
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<td>- Upper respiratory tract infections</td>
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<td>- Pleuropulmonary and bronchial infections.</td>
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<td>- Urinary tract infections</td>
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<td>- Peritonitis and other intra-abdominal infections</td>
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<td>- Cardiovascular infections</td>
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<td>- Central nervous system infections</td>
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<td>- Skin and soft tissue infections</td>
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<td>- Infections related to trauma, burns, and human and animal bites</td>
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<td>- Gastrointestinal infections and food poisoning syndromes</td>
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<td>- Bone and joint infections</td>
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<td><strong>ID Team Attending Rounds</strong></td>
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<td>Curricular Expectations</td>
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<td>• Infections of reproductive organs</td>
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<td>• Sexually transmitted diseases</td>
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<td>• Infections of the eye</td>
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<td>• Viral hepatitides</td>
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<td>• Sepsis syndromes</td>
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<td>• Nosocomial infections</td>
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<td>• Infectious and non-infectious complications of HIV infection and acquired immunodeficiency syndrome</td>
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<td>• Infections in the immunocompromised or neutropenic hosts</td>
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<td>• Infections in acute leukemia and lymphoma</td>
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<td>• Transplant-related infections, including bone marrow and solid organ</td>
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<td>• Infections in geriatric patients</td>
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<td>• Infections in travelers</td>
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<td>• Infections related to intravenous drug abuse</td>
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<td>Demonstrate an understanding of the following:</td>
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<td>• Mechanism of action and adverse reactions to antimicrobial agents</td>
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<td>• Clinical pharmacology of antimicrobial agents</td>
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<td>• Assessing antimicrobial activity of drugs in appropriate clinical setting.</td>
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<td>• Recognize emerging infections/epidemics; principles and practice of hospital infection control.</td>
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<td>• Principles of chemoprophylaxis and immunoprophylaxis</td>
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<td>• Principles and practice of hospital control</td>
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<td>• Mechanisms of action of monoclonal antibodies, cytokines, interferons, interleukins, and colony-stimulating factors/applications; side effects</td>
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<td>• Introduce basic concepts of immunology, host defense mechanisms.</td>
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<td></td>
<td>• Utility of procedures for specimen collection relevant to ID including but not limited to bronchoscopy, thoracentesis, arthrocentesis, lumbar puncture, and aspiration of abscess cavities.</td>
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<td>• ID Team Attending Rounds</td>
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<td>• ID Clinical Conference</td>
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<td>• Reading Lists</td>
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<td>• Core Curriculum Conference</td>
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<td>• Direct Feed-back End-of-Rotation Evaluation</td>
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<td>• ITE/ABFM Board Exam sections on ID</td>
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BMH/CH Family Medicine Inpatient Medicine Rotation (IP)

Contacts: Regina Neal, CH/BMH Residency Coordinator  
Email: Regina.Neal@BMHcc.org  
Phone: (901) 226-1358

Kent Alan Lee, MA. MD. FAAFP., Associate Program Director  
Email: Kent.Lee@bmg.md  
Phone: (479) 462-3259

2 Blocks (4 weeks each) during each resident year

Clinic: 1 day / week Continuity Clinic at Church Health

Rotation Specific Medical Knowledge Goals:

Educational aims: The curriculum of the Inpatient Family Medicine rotation is designed to expose the resident to the full spectrum of inpatient medicine. This is obtained in a longitudinal experience through the course of the training program.

Principle teaching methods:

Supervised direct patient care: The resident will encounter patients admitted to hospitalist services in a community setting. The hospitalist preceptor will supervise admission histories, physical examinations, daily management and discharge plans for patients cared for on the service. Management rounds will be conducted daily and will emphasize the fundamental skills for management of hospitalized patients while incorporating issues such as resource utilization.

Didactic sessions: The resident will participate in educational teaching sessions made available while on this rotation.

AAFP Internal Medicine SAM: The resident will complete the IM SAM available while on this rotation.

Consultation: Consultants may be called upon to answer a specific clinical question related to a hospitalized patient; requested in direct consultation with attending physician.

Mix of Diseases: Patients encountered during this experience will have a variety of conditions ranging from common medical problems to more complex and uncommon medical conditions. Significant opportunities may arise to refine management approaches for patients presenting with new and undifferentiated clinical problems.

*30 Most Common Problems

1. Coronary atherosclerosis (e.g., unstable angina)
2. Pneumonia
3. Congestive heart failure
4. Acute myocardial infarction
5. Acute cerebrovascular disease (e.g., stroke)
6. Cardiac dysrhythmias
7. Chronic obstructive pulmonary disease
8. Back problems
9. Nonspecific chest pain
10. Fluid and electrolyte disorders (e.g., hyponatremia, hypokalemia, dehydration)
Curricular Expectations

11. Biliary tract disease (e.g., cholecystitis, cholelithiasis)
12. Sepsis
13. Asthma
14. Urinary tract infections
15. Diabetes mellitus with complications (e.g., ketoacidosis, hyperosmolar state, foot infections)
16. Skin and subcutaneous tissue infections (e.g., cellulitis)
17. Gastrointestinal hemorrhage
18. Alcohol-related mental disorders
19. Metastatic cancer
20. Diverticulosis and diverticulitis
21. Seizure disorder
22. Pancreatic disorders (e.g., pancreatitis)
23. Syncope
24. Phlebitis, thrombophlebitis and thromboembolism
25. Calculus of urinary tract
26. Abdominal pain
27. Dementia/delirium
28. HIV infection
29. Drug overdose
30. Intestinal infection (e.g., gastroenteritis)

(The above list represents the 30 most common medical conditions, listed in order of frequency, for which adults are most often hospitalized in the US. The source of this information is a list, published by US Agency for Health Care Policy and Research, of the 100 most common hospital diagnoses.)

Independent Reading: The resident will read independently to answer questions about patient care that arise in the clinical setting using primary literature and resources that may have been chosen by the resident or supervising physician.

Patient Characteristics: Patients selected for the resident to see should be representative of hospitalized primary care practice. Ages include from age 18 to the geriatric population.

Attendance: Residents are expected to attend all conferences, meetings, and skill sessions unless emergency patient care responsibilities warrant otherwise. It is expected the appropriate people will be notified of the absence and the session rescheduled. If an inpatient is assigned to a resident physician, that physician should make every effort to make daily visits and write a short social note during the hospitalization.

Beginning of the Block Rounds: A brief orientation to the service will be done at the first of the Block. This will help to assure the smooth transition of patient care and to orient the residents to the service.

Work Rounds: Residents on the service are expected to see their patients before Educational Rounds. This should include interval history, physical and follow up of any testing. It is important that the resident independently develop plans for ongoing evaluation, treatment and discharge prior to Educational Rounds. These plans can be discussed with the inpatient team at that time.

Educational Rounds: The Inpatient Chief will have the option of choosing either “walking” rounds or “sit-down” rounds, Monday through Friday. Residents are expected to have seen their assigned inpatients, write orders and progress notes before either form of rounds. During rounds new admissions will be reviewed and any problems discussed. The bulk of the rounding time will be devoted to the discussion of teaching topics relevant to current patients. Residents are expected to prepare and present a brief topic of interest at least once during the block.
Curricular Expectations

Weekend and Holiday Responsibilities: At the beginning of the block the chief will assign one resident to round on inpatients each weekend and holiday.

Chief of Inpatient Medicine Responsibilities: The most senior resident on the service will serve as chief for the block. This responsibility will be shared when more than one senior resident is on the service. Please see attached list of responsibilities at the end of this section.

End of the Block Rounds: A critical review of the month’s activities will be held with the director of Inpatient Medicine and other interested faculty.

Unscheduled Time: Residents who are not scheduled for a specific educational setting or providing patient care will be expected to utilize the time appropriately and be available to provide additional backup as needed.

Rotation Specific Patient Care and Medical Knowledge Goals:

R1 Year

GOALS:
To develop the knowledge, attitudes, and skills necessary to effectively diagnose and manage common inpatient medical problems of the adult under the supervision of senior residents.

OBJECTIVES:

PATIENT CARE

Interns will:
- Perform appropriate history and physical exam to assess need for hospitalization and to develop a list of differential diagnoses
- Order the appropriate diagnostic tests in order to assist in the diagnosis
- Assess the need for immediate measures to stabilize the patient
- Write appropriate admission orders for initial management and treatment
- Follow-up, in a timely fashion, all pertinent laboratory and imaging results
- Determine the need for additional diagnostic studies
- Arrange appropriate monitoring and decide when a patient will need to be reassessed
- Determine the need for consultation
- Adjust therapeutic plan as needed based on changes in patient’s clinical course
- Arrange discharge planning and follow-up plan
- Identify the indication for and perform the following procedures:
  - Lumbar Puncture
  - Paracentesis
- Report all information regarding the patient’s care to other members of the inpatient team and to consultants involved in the patient’s care

MEDICAL KNOWLEDGE

Interns will, for the 30 most common inpatient problems*:
- Explain the anatomy, pathophysiology, and microbiology involved in pathogenesis of the problem.
Curricular Expectations

- Explain the pharmacology of common medications used in management of the problem.
- List the criteria for admission
- List the criteria for discharge
- List the indications/contraindications for diagnostic tests and interventions.
- List the indications and contraindications for specific invasive procedures needed for management
- Accurately identify the following patterns on an EKG
  - Myocardial infarction and ischemia
  - Arrhythmias, including supraventricular tachycardia, atrial fibrillation and flutter, heart blocks, ventricular tachycardia, and ventricular fibrillation.
- Diagnose the following conditions on x-ray and/or CT:
  - Pneumonia
  - Heart failure
  - Chronic obstructive pulmonary disease
  - Vertebral fractures
  - Ileus
  - Intestinal obstruction
- Interpret an ABG
- Interpret a PFT

PRACTICE-BASED LEARNING AND IMPROVEMENT

Interns will:

- Optimize treatment plans using a systematic approach to medical decision-making and patient care, combining scientific evidence and clinical judgment with patient values and preferences.
- Assess medical information to support self-directed learning
- Practice “just-in-time” learning by using real time online resources (i.e. Up-to-date, Medline, CDC, AFP online etc.) as cases present themselves
- Recognize own limitations of knowledge in diagnosis and management and seek consultation with other health care providers to provide optimal care

INTERPERSONAL AND COMMUNICATION SKILLS

Interns will:

- Write/dictate daily progress notes that provide useful information to other providers
- Educate patients and families effectively about the diagnoses and treatment plans/options
- Update patient and/or family on the hospital course as appropriate
- Obtain informed consent from patients and/or legal representatives for blood transfusions or procedures
- Tactfully deliver news to a patient (and the patient’s family) about a terminal/fatal diagnosis
- Conduct an effective discussion with a patient and/or family regarding a decision to implement end of life care
- Notify a patient's family member that the patient has died
- Provide patients with clear, appropriate discharge instructions
- Document visits thoroughly and accurately in the medical chart
Curricular Expectations

- Respond appropriately to phone calls from outpatients, and from family members of inpatients
- Communicate effectively with the consulting physician
- Prepare and dictate accurate discharge summaries within 24 hours of a patient’s hospital discharge
- Perform clear sign-outs while transitioning care between team members.
- Effectively communicate verbal orders and care plans to nursing staff, in such a way that nurses feel confident in the intern’s skills
- Accept admissions from the emergency department and transfers from other services with collaborative discussion, but without argument

PROFESSIONALISM

Interns will:

- Demonstrate respect for patients
- Demonstrate respect for the medical team
- Maintain patient privacy/confidentiality
- Be on time and prepared for rounds, conferences, and other scheduled inpatient activities
- Respond promptly to phone calls, pages, and emergencies
- Demonstrate appropriate balance in maintaining a personal life and meeting the responsibilities of patient care

SYSTEMS-BASED PRACTICE

Interns will:

- Reflect cost-consciousness when considering diagnostic and therapeutic options
- Recognize presentations that warrant referral to a consulting specialist and demonstrate proper consultation and referral of patients
- Coordinate care and make appropriate referrals, in collaboration with other health professionals, at the time of discharge from hospital
- Order consultations in such a way that consultants understand the reason(s) for the consultation

R2 Year

GOALS:

To further develop the knowledge, attitudes, and skills necessary to effectively diagnose and manage common inpatient medical problems of the adult patient

OBJECTIVES:

PATIENT CARE

Residents will:

- Supervise and instruct interns in performing an appropriate history and physical exam in order to assess need for hospitalization
- Develop a list of differential diagnoses
Curricular Expectations

- Order the appropriate diagnostic tests in order to assist in the diagnosis
- Assess the need for immediate measures to stabilize the patient
- Supervise and assist interns in writing appropriate admission orders for initial management and treatment
- Follow-up, in a timely fashion, all pertinent laboratory and image results
- Determine the need for additional diagnostic studies
- Arrange appropriate monitoring and decide when a patient will need to be reassessed
- Determine the need for consultation
- Adjust therapeutic plan as needed based on changes in patient’s clinical course
- Assist interns in developing and arranging appropriate discharge and follow-up plans
- Identify the indication for and perform the following procedures:
  - Lumbar Puncture
  - Paracentesis
- Integrate all information regarding the patient and his/her care and recommend to other members of the inpatient team and to consultants involved in the patient’s care a logical and correct diagnostic and management plan for each patient under their care
- Appropriately supervise interns and MS4 students in their patient care activities

MEDICAL KNOWLEDGE

Residents will, for the 30 most common inpatient problems*:

- Explain the anatomy, pathophysiology, and microbiology involved in pathogenesis of the problem.
- Explain the pharmacology of common medications used in management of the problem.
- List the criteria for admission and for discharge
- List the indications/contraindications for diagnostic tests, interventions/invasive procedures needed for management
- Accurately identify the following patterns on an EKG:
  - Myocardial infarction
  - Arrhythmias, including supraventricular tachycardias, atrial fibrillation and flutter, heart blocks, ventricular tachycardia, and ventricular fibrillation
- Diagnose the following conditions on x-ray and/or CT:
  - Pneumonia
  - Heart failure
  - Chronic obstructive pulmonary disease
  - Vertebral fractures
  - Ileus
  - Intestinal obstruction
- Interpret an ABG
- Interpret a PFT

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents will:
Curricular Expectations

- Optimize treatment plans using a systematic approach to medical decision-making and patient care, combining scientific evidence and clinical judgment with patient values and preferences.
- Assess medical information to support self-directed learning
- Practice “just-in-time” learning by using real time online resources (i.e. Up-to-date, Medline, CDC, AFP online etc.) as cases present themselves
- Recognize own limitations of knowledge in diagnosis and management and seek consultation with other health care providers to provide optimal care

INTERPERSONAL AND COMMUNICATION SKILLS

Residents will:

- Respectfully and effectively provide feedback to interns and medical students regarding their patient care management
- Educate patients and families effectively about the diagnoses and treatment plans/options
- Update patient and/or family on the hospital course as appropriate
- Obtain informed consent from patients and/or legal representatives for blood transfusions or procedures
- Tactfully deliver news to a patient (and the patient’s family) about a terminal/fatal diagnosis
- Conduct an effective discussion with a patient and/or family regarding a decision to implement end of life care
- Notify a patient’s family member that the patient has died
- Provide patients with clear, appropriate discharge instructions
- Document visits thoroughly and accurately in the medical chart
- Respond appropriately to phone calls from outpatients, and from family members of inpatients
- Communicate effectively with the consulting physician
- Write/dictate daily progress notes that provide useful information to other providers
- Prepare and dictate accurate discharge summaries within 24 hours of a patient’s hospital discharge
- Perform clear sign-outs while transitioning care between team members.
- Effectively communicate verbal orders and care plans to nursing staff, in such a way that nurses feel confident in the resident’s skills
- Accept admissions from the emergency department and transfers from other services with collaborative discussion, but without argument

PROFESSIONALISM

Residents will:

- Demonstrate respect for patients
- Demonstrate respect for the medical team
- Maintain patient privacy/confidentiality
- Be on time and prepared for rounds, conferences, and other scheduled inpatient activities
- Respond promptly to phone calls, pages, and emergencies
- Demonstrate appropriate balance in maintaining a personal life and meeting the responsibilities of patient care

SYSTEMS-BASED PRACTICE
Residents will:

- Reflect cost-consciousness when considering diagnostic and therapeutic options
- Recognize presentations that warrant referral to a consulting specialist and demonstrate proper consultation and referral of patients
- Coordinate care and make appropriate referrals, in collaboration with other health professionals, at the time of discharge from hospital
- Order consultations in such a way that consultants understand the reason(s) for the consultation
- Arrange with health providers in outlying hospitals to receive a patient in transfer
- Arrange for scheduling of an urgent diagnostic test (e.g., CT scan, ultrasound) when schedules for such testing are initially said to be full

R3 Year

GOALS:

To further develop the knowledge, attitudes, and skills necessary to effectively and independently diagnose and manage common inpatient medical problems of the adult patient so as to prepare them for independent inpatient work after graduation from residency

OBJECTIVES:

PATIENT CARE

Residents will:

- Supervise and instruct interns in performing an appropriate history and physical exam in order to assess need for hospitalization
- Develop a list of differential diagnoses
- Order the appropriate diagnostic tests in order to assist in the diagnosis
- Assess the need for immediate measures to stabilize the patient
- Supervise and assist interns in writing appropriate admission orders for initial management and treatment
- Follow-up, in a timely fashion, all pertinent laboratory and image results
- Determine the need for additional diagnostic studies
- Arrange appropriate monitoring and decide when a patient will need to be reassessed
- Determine the need for consultation
- Adjust therapeutic plan as needed based on changes in patient’s clinical course
- Assist interns in developing and arranging appropriate discharge and follow-up plans
- Identify the indication for and perform the following procedures:
  - Lumbar Puncture
  - Paracentesis
- Integrate all information regarding the patient and his/her care and recommend to other members of the inpatient team and to consultants involved in the patient’s care a logical and correct diagnostic and management plan for each patient under their care
- Appropriately supervise interns and MS4 students in their patient care activities
MEDICAL KNOWLEDGE
Residents will, for the 30 most common inpatient problems*:
- Explain the anatomy, pathophysiology, and microbiology involved in pathogenesis of the problem. Explain the pharmacology of common medications used in management of the problem.
- List the criteria for admission and for discharge
- List the indications/contraindications for diagnostic tests, interventions/invasive procedures needed for management
- Accurately identify the following patterns on an EKG:
  - Myocardial infarction
  - Arrhythmias, including supraventricular tachycardias, atrial fibrillation and flutter, heart blocks, ventricular tachycardia, and ventricular fibrillation
- Diagnose the following conditions on x-ray and/or CT:
  - Pneumonia
  - Heart failure
  - Chronic obstructive pulmonary disease
  - Vertebral fractures
  - Ileus
  - Intestinal obstruction
- Interpret an ABG
- Interpret a PFT

PRACTICE-BASED LEARNING AND IMPROVEMENT
Residents will:
- Optimize treatment plans using a systematic approach to medical decision-making and patient care, combining scientific evidence and clinical judgment with patient values and preferences.
- Assess medical information to support self-directed learning
- Practice “just-in-time” learning by using real time online resources (i.e. Up-to-date, Medline, CDC, AFP online etc.) as cases present themselves
- Recognize own limitations of knowledge in diagnosis and management and seek consultation with other health care providers to provide optimal care

INTERPERSONAL AND COMMUNICATION SKILLS
Residents will:
- Respectfully and effectively provide feedback to interns and medical students regarding their patient care management
- Educate patients and families effectively about the diagnoses and treatment plans/options
- Update patient and/or family on the hospital course as appropriate
- Obtain informed consent from patients and/or legal representatives for blood transfusions or procedures
Curricular Expectations

- Tactfully deliver news to a patient (and the patient’s family) about a terminal/fatal diagnosis
- Conduct an effective discussion with a patient and/or family regarding a decision to implement end of life care
- Notify a patient’s family member that the patient has died
- Provide patients with clear, appropriate discharge instructions
- Document visits thoroughly and accurately in the medical chart
- Respond appropriately to phone calls from outpatients, and from family members of inpatients
- Communicate effectively with the consulting physician
- Write/dictate daily progress notes that provide useful information to other providers
- Prepare and dictate accurate discharge summaries within 24 hours of a patient’s hospital discharge
- Perform clear sign-outs while transitioning care between team members.
- Effectively communicate verbal orders and care plans to nursing staff, in such a way that nurses feel confident in the resident’s skills
- Accept admissions from the emergency department and transfers from other services with collaborative discussion, but without argument

PROFESSIONALISM

Residents will:

- Demonstrate respect for patients
- Demonstrate respect for the medical team
- Maintain patient privacy/confidentiality
- Be on time and prepared for rounds, conferences, and other scheduled inpatient activities
- Respond promptly to phone calls, pages, and emergencies
- Demonstrate appropriate balance in maintaining a personal life and meeting the responsibilities of patient care

SYSTEMS-BASED PRACTICE

Residents will:

- Maximize continuity of care for inpatients and outpatients
- Demonstrate respect for patients
- Demonstrate respect for the medical team
- Maintain patient privacy/confidentiality
- Be on time and prepared for rounds, conferences, and other scheduled inpatient activities
- Respond promptly to phone calls, pages, and emergencies
- Demonstrate appropriate balance in maintaining a personal life and meeting the responsibilities of patient care

Inpatient Chief (Senior) Resident responsibilities:

The chief of the Inpatient Service is an administrative and educational position as well as a clinical one. Not only is the chief expected to oversee the clinical aspects of care of all inpatients, but also to administratively run the service. The
Curricular Expectations

The chief functions as a junior faculty for the service and in many ways is expected to support and to be a resource for the interns on the team.

Clinical Responsibilities:

- Follow all patients on service along with interns and sub-interns and understand treatment plans.
- Perform daily chart audits on all patients to ensure patient care plans are being adhered to.
- Physically see all new and sick patients and help intern formulate care plans.
- The chief is expected to be available from 0700-1800 weekdays.

Team Leadership:

- Assign overnight admissions to team members by 7am in a fair manner. Run the morning report efficiently.
- Be available for and assist in triage of consultations and admissions.
- Assign weekend rounding responsibilities equally.
- Make sure attendance at 1030 rounds is prompt.
- Be a good role model for the interns.
- Assist supervising attending in documentation for billing for the services provided.
- Help run inpatient rounds efficiently to ensure that all members attend noon conference.

Teaching:

- The chief is responsible for coordinating teaching topics for 1030 rounds and at other times as appropriate. All residents are expected to take part in teaching the rest of the team.
- During daily chart audits, coach interns for good notes and orders.

Sub-Internship Medical Student:

- Actively involve medical student on Sub-I Rotation by assigning patients to follow and having them do initial H&P’s in clinic or the ER. It is optimal if the student conducts initial H&P’s on 2-3 admissions per week and is assigned ongoing rounding responsibilities for 1-3 patients per day. The Sub-I should be working directly under the chief as much as possible.
- Make sure all orders/notes are co-signed.
- Help orient the Sub-I including a tour of the facilities, charting and computer systems at SL and Mercy.
- At the end of their time, the residents on the Inpatient Medicine Service and faculty should evaluate the student and return their evaluation form promptly back to Gina Rogers, GME System Coordinator.

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<tr>
<th>Specific Medical Knowledge Objective</th>
<th>Method of Evaluation</th>
<th>Expected Outcome</th>
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<tr>
<td>Inpatient Care: The residents on the Inpatient Medicine Service will provide inpatient care for their own patients, patients of residents on the AOC rotations, patients of residents on out-of-town rotations or otherwise away from the residency, patients of faculty members, and unassigned patients. The service will also provide consultative services to other physicians on the hospital staffs.</td>
<td>Direct observation</td>
<td>Satisfactory course eval and ITE scores; expectation of Milestone Level 3 in appropriate patient care skills by end of intern year; 3.5 at end of R2 year and 4 at end of R3 year</td>
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<td>- Be involved in and assume increasing responsibility for the daily care of assigned patients commensurate with one’s abilities and under the supervision of the attending physician</td>
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<th>Curricular Expectations</th>
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<tr>
<td>• Develop communication skills needed in patient hand-offs.</td>
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<td>• Be aware of and utilize current literature in the management of inpatient problems.</td>
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<td>• Realize time management strategies while functioning as a physician on an inpatient service.</td>
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<td>• Medical Decision-Making, Clinical Judgment, and Management Plans: The resident will demonstrate improving skills in assimilating information that they have gathered from the patient’s history and physical examination.</td>
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<td>• Regularly integrates medical facts and clinical data while weighing alternative and keeping in mind patient preference.</td>
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<td>• Presents current scientific evidence to support hypotheses.</td>
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<td>• Consistently monitors and follow-ups with patients appropriately.</td>
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<td>• Develops plans to avoid or delay known treatment complications and identifies when illness has reached a point when treatment no longer contributes to quality of life.</td>
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<td>• Does not overly rely on tests or procedures.</td>
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<td>• Continuously revises assessments in the face of new data.</td>
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<td>• Tailors the therapeutic plan that takes into account discharge plan and outpatient resources.</td>
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<td>• Pain Management:</td>
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<td>• Learns to properly assess pain as a presenting and/or accompanying symptom of hospitalized patients</td>
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<td>• Elicits a detailed biopsychosocial history and description of pain, reviews the medical record to determine likely source of pain and conducts a physical examination to determine the likely source of pain.</td>
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<td>• Utilizes evidence-based recommendations to approach pain management.</td>
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<td>• Patient Counseling:</td>
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<td>• Explains the advantages and disadvantages of competing therapeutic interventions.</td>
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<td>• Educates patient and families for enhanced compliance.</td>
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| 198 | (competent for independent practice) |
- Communicates effectively with critically ill patients and those making life-style modifications.

**Management of Patients:**
- Handles increasing number of tasks related to care of patients including prioritizing care as well as handling tasks across the patients on the team.
- Coordinates care amongst specialty providers and other healthcare personnel.
- Begin to understand a systems-based approach to healthcare as part of hospital medicine.

**Various interpretive skills reinforced or learned during the elective include but are not limited to:**
- Serum electrolytes and routine chemistry panel, complete blood count with differential, liver function tests, and coagulation studies
- Urinalysis and microscopic examination of urine
- Arterial blood gases
- Chest X-ray and Electrocardiogram interpretation
- Blood, Urine, Sputum, and Exudate Cultures
- Spirometry

- Develop skills in performing diagnostic procedures—paracenteses, thoracenteses, arthrocenteses, lumbar punctures, etc.—common to internal medicine and pertinent to family medicine

**Emergency Room Responsibilities:** During the rotation, residents will provide care to patients in the emergency room if inpatient admission is required or if the ER physician requests further evaluation. The ER physicians will otherwise provide for the routine care for any of our patients that come to the ED

- Develop a strong fund of knowledge in the pathophysiology and natural history of disease
- Perform comprehensive histories and physicals
- Develop a thorough and appropriate differential diagnosis, a plan of evaluation including the use of laboratory and x-ray, and a course of management of the medical problems of the patients

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<tr>
<th>Direct observation</th>
<th>Satisfactory course eval and ITE scores; Milestone evaluation progression as above</th>
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**Pharmacology**

The resident will have the opportunity to review the pharmacological management of various disease states. The resident will have a basic understanding of common drug interactions and side effects as well as, therapeutic drug selection and monitoring issues.

**Coding**

The resident will refine their practice management skills by reviewing their coding of inpatient records to ensure they have complete knowledge of the process. One session is done each block or eight sessions over three years.

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<th>Curricular Expectations</th>
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<tr>
<td><strong>Pharmacology</strong></td>
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<td>The resident will have the opportunity to review the pharmacological management of various disease states. The resident will have a basic understanding of common drug interactions and side effects as well as, therapeutic drug selection and monitoring issues.</td>
</tr>
<tr>
<td><strong>Coding</strong></td>
</tr>
<tr>
<td>The resident will refine their practice management skills by reviewing their coding of inpatient records to ensure they have complete knowledge of the process. One session is done each block or eight sessions over three years.</td>
</tr>
<tr>
<td><strong>Direct Observation</strong></td>
</tr>
<tr>
<td><strong>Satisfactory Course Evaluation; Milestone evaluation progression as noted above</strong></td>
</tr>
</tbody>
</table>
Curricular Expectations

BMH/ CH Family Medicine Care of Infants and Children (Inpatient Pediatrics)

Contacts: Regina Neal, CH/BMH Residency Coordinator
e-mail: Regina.Neal@BMHcc.org
phone: (901) 226-1358

Kent Alan Lee, MA. MD. FAAFP., Associate Program Director
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phone: (479) 462-3259

Schedule: 4 week (1 block) in both Intern and second year

Expectations:
- Participate in rounds
- Charting
  - Attend some high risk deliveries with NICU
  - Participate in “head of bed assessments” (ability to assess neonate in first 2 hours of life: what is normal vs. “sick”: focus on 34 weeks and later)
  - Attend some (5-10) deliveries (NSVD and C/S) with Birth Attendant (notify BA of your availability)

Clinic:
- Continuity Clinic 1 day per week

Rotation Preparation: NRP and PALS Certification

The objectives of the Newborn component of the rotation are to develop skills in newborn assessment and resuscitation; to learn techniques of circumcision; to learn when to seek consultation; and to facilitate the mother-infant unit by communicating evidence-based practice to the mother and family of the newborn.

PGY 1 should achieve equivalent of Milestone level 2.5 on end of rotation specific evaluation, and perform at expected level on ITE over Inpatient Pediatrics

PGY 2 should achieve equivalent of Milestone level 3.5 on end of rotation specific evaluation, and perform at expected level on ITE over Inpatient Pediatrics

Rotation Specific Medical Knowledge Goals:

<table>
<thead>
<tr>
<th>In the appropriate setting, the resident should demonstrate the ability to apply knowledge of <strong>Fetal and neonatal period</strong></th>
<th>Milestone Level 3-4 on end rotation evaluation ITE exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Risk factors determined by gestational age assessment</td>
<td></td>
</tr>
<tr>
<td>2. Effects of labor and delivery on the infant</td>
<td></td>
</tr>
<tr>
<td>3. Adaptations to extrauterine life</td>
<td></td>
</tr>
<tr>
<td>4. Newborn metabolic screening</td>
<td></td>
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<tr>
<td>5. Feeding/ Growth and caloric requirements</td>
<td></td>
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<tr>
<td>6. Sudden infant death syndrome (SIDS)</td>
<td></td>
</tr>
<tr>
<td>7. Diagnosis of congenital and genetic diseases</td>
<td></td>
</tr>
<tr>
<td>a. Meconium-stained amniotic fluid</td>
<td></td>
</tr>
</tbody>
</table>
Curricular Expectations

<table>
<thead>
<tr>
<th>b. Perinatal asphyxia</th>
<th>Curricular Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Respiratory distress</td>
<td></td>
</tr>
<tr>
<td>d. Cyanosis</td>
<td></td>
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<tr>
<td>e. Apnea</td>
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<td>f. Seizures</td>
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<td>g. Hypoglycemia</td>
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<tr>
<td>h. Evaluations of possible sepsis</td>
<td></td>
</tr>
<tr>
<td>i. Developmental dysplastic hip</td>
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<tr>
<td>j. Birth-related injuries</td>
<td></td>
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<tr>
<td>k. Neonatal abstinence syndrome (in utero drug exposure)</td>
<td></td>
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<tr>
<td>l. Anemia</td>
<td></td>
</tr>
<tr>
<td>m. Rh factor and blood type incompatibility</td>
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<tr>
<td>n. Polycythemia</td>
<td></td>
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<tr>
<td>o. Jaundice</td>
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<tr>
<td>p. Premature and post-date gestations</td>
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<tr>
<td>q. Maternal infections (HIV, hepatic etc)</td>
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</tbody>
</table>

Demonstrates and Overall Approach to evaluating the health of a Neonate

<table>
<thead>
<tr>
<th>Direct Observation</th>
<th>Milestone Level 3-4 on rotation end evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide effective preventive health care and health care risk factor reduction to patients and their families.</td>
<td></td>
</tr>
<tr>
<td>Counsel patients and their families about safe and effective care of their newborns.</td>
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</tr>
<tr>
<td>Describe the necessary medical equipment for neonatal resuscitation and demonstrate its proper use.</td>
<td></td>
</tr>
</tbody>
</table>

Accurately assess and manage normal and high-risk newborn immediately following delivery including:

1. Assessing the need of immediate resuscitation
2. Assigning the 1-, 5-, and subsequent Apgar scores
3. Using appropriate technique for suctioning the nose and mouth.
4. Demonstrating steps to reduce radiant heat loss.
5. Demonstrating bag and mask ventilation.
6. Demonstrating intubation and ventilation.
7. Performing cardiac compression.
8. Demonstrating cardiac compression.
9. Demonstrating appropriate use of medications.
10. Rapidly inspecting for signs of major malformations.

For these common conditions, demonstrate delivery room assessment and management and list criteria for neonatal consultation:

1. Meconium stained fluid
2. Respiratory depression from:
   a. Maternal anesthesia
   b. Medications
   c. Substance use/abuse
3. Complicated delivery:
   a. C/S problems
   b. Instrument-assisted deliveries
   c. Breech presentation
   d. Cord prolapse
   e. Placental abruption
Discuss immediate breastfeeding and early bonding between baby and family.

In the nursery obtain and interpret information relevant to newborn health including:

1. Maternal medical, prenatal and obstetric history
2. Family history
3. Maternal medication use
4. Maternal substance use/abuse
5. Results of prenatal ultrasound testing
6. Describe the rationale and use of prophylaxis
   a. Vitamin K
   b. Erythromycin ointment for eye
   c. Hepatitis B vaccine
7. Perform a neonatal physical exam and identify normal and abnormal findings:
   a. Gestational age assessment
   b. Vital signs
      i. Fever
      ii. Temperature stability
   c. Identification of anomalies
   d. HEENT
      i. Red reflex/subconjunctival hemorrhages
      ii. Palette
      iii. Frenulum
      iv. Caput
      v. Cephalohematoma
      vi. Ear placement
      vii. Head size
      viii. Neck and clavicles
   e. Neurological system
      i. Symmetry
      ii. Tone
      iii. Reflexes
      iv. Suck
      v. Spine
      vi. Facial palsy
   f. Sacral dimple or tuft
   g. Respiratory - tachypnea/distress
   h. Skin
      i. Mongolian spots
      ii. Hemangiomas
      iii. Port wine stains
      iv. Papular and pustular rashes
         1. Erythema toxicum
### Curricular Expectations

2. Milia
3. Staph pustulosis
   v. Peripheral and central cyanosis
   i. Chest and breast (buds +/-)
   j. Heart
      i. Asymptomatic
      ii. Symptomatic
   k. Lungs (crackles/fluid)
   l. Abdomen
      i. Masses
      ii. Umbilical cord (#vessels)
   m. Genitalia
      i. Male (hypospadias, testicles, hernia)
      ii. Female – bleeding?
   n. Femoral and brachial pulses
   o. Hips (dysplasia)

Recognize, describe clinical significance of, and develop a strategy to evaluate, manage and/or refer.

1. LGA and SGA babies-feeding plans
2. Infant of a diabetic mother
3. Infant of a substance abusing mother
4. Infant born to mother with fever
5. Infant born to mother with perinatal infectious disease:
   a. Group B strep
   b. Chlamydia
   c. Syphilis
   d. HSV
   e. HIV
   f. TB
   g. Parvovirus
   h. Rubella
   i. Toxoplasmosis
   j. Varicella
6. Child with ABO/Rh incompatibility
7. Polycythemia
8. Premature/post-mature infant
9. Jitteriness
10. Transient metabolic disturbances
11. Delayed urination
12. Delayed stooling
13. Vomitus feeds/bilious emesis
14. Poor/delayed suck
15. Respiratory distress with feedings
16. Jaundice
   a. Interpreting maternal risk factors for jaundice
      i. Rh
      ii. Blood type
Curricular Expectations

iii. Gestational age
iv. Infection
v. Family history

b. Interpreting infant’s history
   i. Ineffective feeding
   ii. Poor urine or stool output
   iii. Acholic stool
   iv. Blood type
   v. Metabolic disease

c. Interpretation of transcutaneous bilirubin monitoring

d. Obtain correct laboratory tests
   i. Blood type/Coombs
   ii. Total and fractionate bilirubin
   iii. Hct
   iv. Peripheral blood smear

e. Describe indications for phototherapy and exchange transfusions

f. Supporting breastfeeding in the jaundiced infant

17. Infant with risks for hip dysplasia
   a. Breech
   b. Family history

18. Abnormal fetal U/S findings
   a. Hydronephrosis
   b. Choroid-plexus cyst

19. Multiple births

20. Eye discharge

21. Abnormal hearing screen results

Evaluation by direct Observation, with expectation of Milestone Level 3-4 on end rotation evaluation; and passing score over Newborn Care section on ITE

Inpatient Pediatric Rotation Specific Goals:

- Evaluate and admit patients from ER and from out-patient clinics
- Demonstrate the ability to take an age-appropriate history and perform a physical exam
- Synthesize an appropriate diagnosis and treatment plan for common pediatric conditions.
- Demonstrate the ability to communicate effectively with the patient, as well as the patient’s family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood.
- Recognize self-limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care.

The resident should demonstrate attitudes that encompass:

- Empathic concern for the health of the child in the context of the family.
- The importance of continuity and access to care for prevention of illness.
- Promotion of healthy lifestyles in children and families.
Curricular Expectations

- An awareness of the unique vulnerabilities of infants and children that may require special attention, consultation and/or referral.
- An awareness of social, cultural and environmental factors that impact the health and well-being of infants and children.
- The importance of educating the public about environmental factors that can adversely affect children and about development of community programs to promote the health of children.
- The importance of obtaining information about school performance and learning disabilities.

PGY 1 should achieve equivalent of Milestone level 2.5 on end of rotation specific evaluation, and perform at expected level on ITE over Inptent Pediatrics

PGY 2 should achieve equivalent of Milestone level 3.5 on end of rotation specific evaluation, and perform at expected level on ITE over Inpatient Pediatrics

Medical Knowledge Objectives:

Relating to infants and children that may be the etiology of, or contribute to hospitalization, the resident is expected to access appropriate evidenced-based literature.

Allergic:
- Asthma
- Atopy
- Allergic rhinitis

Inflammatory:
- Juvenile rheumatoid arthritis
- Vasculitis syndromes
- Kawasaki disease
- Henoch-Schönlein purpura

Renal and urologic:
- Glomerulonephritis
- Hematuria and proteinuria
- Urinary tract infections, including pyelonephritis
- Vesicoureteral reflux
- Hypospadias, urethral prolapse, fused labia
- Enuresis
- Undescended testis

Endocrine/metabolic and nutritional problems:
- Thyroid disorders
- Diabetes mellitus, type 1 and type 2
- Obesity
- Failure to thrive
- Abnormal growth patterns (short and tall stature)

Neurologic problems:
Curricular Expectations

- Seizure disorders
- Headache
- Syncope
- Psychomotor delay and cerebral palsy
- Tics and movement disorders

Common skin problems:

- Atopic dermatitis
- Viral exanthema and enanthema
- Bites and stings
- Bacterial and fungal infections
- Lice and scabies
- Diaper rash
- Acne
- Urticaria and erythema multiforme
- Burns

Musculoskeletal problems:

- Clubfoot
- Developmental dysplasia of the hip
- Rotational problems and gait abnormalities
- In- and out-toeing
- Metatarsus adductus
- Medial tibial torsion
- Femoral anteversion
- Scoliosis (idiopathic or acquired)
- Aseptic necrosis of the femoral head (Legg-Calvé Perthes disease)
- Slipped capital femoral epiphysis
- Common sprains, dislocations and fractures
- Limping

Gastrointestinal problems:

- Gastroenteritis (viral and bacterial)
- Constipation and encopresis
- Hepatitis
- Colic
- Gastrooesophageal reflux
- Food intolerance and malabsorption
- Pyloric stenosis
- Intussusception
- Appendicitis and peritonitis
- Recurrent and chronic abdominal pain
- Hernia
- Bilious emesis
- Hematemesis
- Hematochezia
Curricular Expectations

Cardiovascular problems:
- Congenital heart disease and valvular disease
- Evaluation of heart murmurs
- Chest pain
- Hypertension

Respiratory tract problems:
- Viral upper respiratory tract infections
- Reactive airway disease and asthma
- Cystic fibrosis
- Bronchiolitis
- Foreign body aspiration
- Viral or bacterial pneumonia
- Pertussis
- Tonsillitis, pharyngitis, sinusitis
- Epiglottitis versus croup
- Epistaxis
- Bacterial tracheitis
- Snoring
- Obstructive sleep apnea

Ear problems:
- Otitis media (acute and with effusion)
- Otitis externa
- Hearing loss
- Wax and foreign body in ear canal

Eye problems:
- Amblyopia
- Strabismus
- Lacrimal-duct stenosis
- Decreased visual acuity
- The red eye
- Congenital cataracts
- Dacryocystitis
- Coloboma

Other serious infections:
- Sepsis and sepsis syndromes
- Meningitis and encephalitis
- Invasive streptococcal and staphylococcal disease
- Osteomyelitis
- Human immunodeficiency virus (HIV)

Lymphatic problems:
- Reactive lymphadenopathy
Curricular Expectations

- Cervical adenitis

Childhood malignancies:
- Lymphoma
- Neuroblastoma
- Wilms’ tumor
- Leukemia

Evaluation: By preceptor through direct observation and oral presentations, and ITE.

Expected Outcome: Milestone Level 3-4 on end rotation evaluation, and appropriate progress on ITE scores.

PGY1: expected level on end rotation evaluation to correlate with Milestone Level 2.5

PGY2: expected level on end of rotation evaluation to correlate with Milestone Level 3.5; complete SAM on Childhood Illness
BMH/CH Family Medicine Maternity Care Rotation (OB)

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phone: (901) 226-1358

Kent Alan Lee, MA. MD. FAAFP., Associate Program Director
email: Kent.Lee@bmg.md
phone: (479) 462-3259

Maternity care rotations for CH/BMH residents are arranged in two, four week blocks, one each in the first and second year of residency.

Residents will obtain substantial additional maternity care experience throughout their training in the CH clinic, by participating in continuity prenatal care of low risk gestations selected for their patient panel.

At the end of each four week block, an evaluation will be sent to the physician sponsor for that rotation, or their representative, to be completed and sent back to the CH/BMH FM residency coordinator for tabulation. If more than one physician participated in resident instruction that month, they may also do an evaluation.

OB Objectives:
The objectives of the maternity care component of the rotation are as follows:

- Develop skills in comprehensive prenatal, intrapartum, and postpartum care
- Develop and refine techniques for normal and vacuum extractor vaginal deliveries
- List and discuss common complications seen in labor and delivery
- List instances and discuss circumstances in which it is prudent for a family physician to seek consultation with an obstetrician-gynecologist, maternal fetal specialist, or neonatologist
- Demonstrate the ability to appropriately perform a spontaneous vaginal delivery

Resident Responsibilities:

Rotation Preparation:

1. Advanced Life Support in Obstetrics (ALSO)
2. AWHONN – Fetal Heart Monitoring Program
3. BLS/ACLS
4. Neonatal Resuscitation Program
5. Introduction to the operating room - Learn scrub technique from Baptist Women’s Nursing Staff
6. Read curriculum policy manual at least 2 weeks prior to starting rotation
7. Recording a procedure log of cases during the rotation.

Procedural Responsibilities:

** Attending is required to be present for all non-emergent procedures **

1. Management of labor
2. Local block anesthesia
Curricular Expectations

3. Induction of labor
   a. Cervidil placement
   b. Cytotec use
   c. Pitocin induction and augmentation
4. Scalp electrode placement
5. Intrauterine catheter placement – amnioinfusion for fetal resuscitation
   a. Amnioinfusion for fetal resuscitation
6. Normal cephalic delivery
   a. Vacuum extraction delivery
   b. Other instrumental deliveries
7. Episiotomy
8. Repair of 1st, 2nd, and 3rd degree vaginal lacerations
   a. Management of vaginal hematoma
9. Management of vaginal hematoma
10. Exploration of vagina, cervix and uterus after delivery
11. Manual extraction of the placenta
12. Management of common post-partum problems
   a. Post-partum hemorrhage
   b. Endometritis
13. First assist at C-section
   a. Tocolysis
   b. Accelerating fetal lung maturity with steroids
15. Microscopic diagnosis of urine and vaginal secretions (including amniotic fluid)
16. Circumcision

Interpretive Responsibilities

1. Fetal heart tracing evaluation and management
2. Maternal ultrasound – Biophysical Profile interpretation
   a. Biophysical Profile
3. Internal fetal monitor evaluation
4. Intra-uterine catheter pressure evaluation (Montevideo units)

Other Core Skills

1. Emotional preparation for, and a sensitive thorough performance of, the obstetrical examination in patients of a child-bearing age.
2. Pre-pregnancy planning and counseling
3. Indications for caesarian section.
4. Lactation
5. Family Life Education
   a. Family planning
   b. Fertility problems
   c. Intra-conceptional care
   d. Family and sexual counseling
6. Consultation and referral
   a. The role of the obstetrician and perinatologist
   b. Women’s health care delivery systems
PATIENT CARE

Overall Goals:
- Demonstrate competence in providing care for pregnant patients and their newborn.
- Competently manage obstetrical patients and newborns and recognize and stabilize those who need specialty care.
- Engage in discussion with families about the medical, psychosocial and family/community issues associated with the obstetrical and newborn patient.
- Faculty will observe residents on all procedural training. Documentation of all observed, assisted and performed procedures is to be completed daily in New Innovations. Precepting faculty should sign off on logs weekly.

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and carry out patient care plans, using principles of evidence-based decision-making, appropriate prioritization, and taking into account the needs, beliefs and resources of patient and family.</td>
<td>Direct observation</td>
<td>Passing Scores on Rotation Evaluation Meeting Institutional Benchmarks on Patient Evaluations</td>
</tr>
<tr>
<td>- Perform a comprehensive women's health history</td>
<td>Rotation Evaluation</td>
<td></td>
</tr>
<tr>
<td>- Perform an adequately detailed OB intake visit</td>
<td>Patient Evaluation</td>
<td></td>
</tr>
<tr>
<td>- Present an adequately detailed OB intake visit to faculty</td>
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<tr>
<td>- Discuss methods for accurate determination of gestational age</td>
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<tr>
<td>- Measure fundal height appropriately</td>
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<tr>
<td>- Demonstrate the ability to correctly determine gestational age using last menstrual period and/or early ultrasound</td>
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<tr>
<td>- Discuss indications for primary care of pregnant women for solo care by family physicians and settings in which shared care or transfer of care are indicated</td>
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<tr>
<td>- Discuss common indication for and contraindications to labor induction</td>
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<tr>
<td>- Define and discuss the stages of labor</td>
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</tbody>
</table>

Effectively use common therapies within the scope of obstetrical practice, including a variety of prescription and non-prescription medications, intravenous fluids, inhalation treatments, as well as special diets and nutritional supplements. Be familiar with obstetrical interventions used by obstetricians

<table>
<thead>
<tr>
<th></th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
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<tbody>
<tr>
<td>- Demonstrate the ability to perform amniotomy, fetal scalp electrode placement, intrauterine pressure catheter placement (IUPC)</td>
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<tr>
<td>- Demonstrate ability to manage labor induction with cervical ripening agents and labor augmentation using Pitocin</td>
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<tr>
<td></td>
<td>Direct observation Rotation Evaluation Skills check offs</td>
<td>Direct observation Passing Score Rotation Evaluation Passing score on clinical check offs</td>
</tr>
</tbody>
</table>
### Curricular Expectations

- Demonstrate ability to follow and document labor using cervical checks, determination of Montevideo units, and progress in labor
- Demonstrate an ability to perform active management of the third stage of labor
- Discuss benefits and limitations of external fetal monitoring and demonstrate ability to interpret fetal heart rate tracing using NHI criteria
- Discuss indications for episiotomy and demonstrate ability to repair first and second degree tears
- Participate in normal spontaneous vaginal deliveries

Counsel patients and families in a supportive manner so they can understand their illness or injury and its treatment, share in decision-making, make informed consent and participate actively in the care plan.

- Counsel patients on basic diet and nutrition during pregnancy
- Counsel patients on breastfeeding
- Provide post-partum counseling on contraception

Counsel patients on obstetrical options, risks, and benefits of procedures. Be able to refer appropriately

- Discuss common birth options (vaginal delivery vs. cesarean on demand) including when inductions can be safely done
- Discuss basic timelines for genetic prenatal testing and role of MFM and geneticists in prenatal care
- Discuss use of medications and substances during pregnancy; counsel patients on best choices
- Discuss importance of early breastfeeding and bonding in the immediate postpartum period

Provide effective preventive health care and health care risk factor reduction to patients and their families.

<table>
<thead>
<tr>
<th>Demonstrate ability</th>
<th>Direct Observation</th>
<th>Direct observation</th>
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<tbody>
<tr>
<td></td>
<td>Rotation Evaluation</td>
<td>Passing Score Rotation Evaluations</td>
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<td>Video taping</td>
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</table>

For these common conditions, discuss assessment and management of each condition. When possible, demonstrate skills when working with at-risk patients. List indications for consultation of obstetricians or MFM.

4. Meconium stained fluid
5. Management of group B strep positive mothers
6. Respiratory depression from:
Curricular Expectations

b. Maternal anesthesia
c. Medications
d. Substance use/abuse

7. Precipitous delivery
8. Complicated delivery:
d. C/S problems
e. Instrument-assisted deliveries
f. Breech presentation
g. Cord prolapse
h. Abruptio placentae
i. Oligo- and Polyhydramnios

Discuss immediate breastfeeding and early bonding between baby and family.

**MEDICAL KNOWLEDGE**

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
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</thead>
<tbody>
<tr>
<td>Learners will successfully complete the Advanced Life Support in Obstetrics (ALSO) course prior to participating in the rotation</td>
<td>ALSO Training Course</td>
<td>Passing Scores on ALSO course</td>
</tr>
</tbody>
</table>

**Diagnosis of Pregnancy/first trimester care**
- Learners will be able to discuss basic first trimester physiology
- Learners will be able to list basic methods for confirming pregnancy
- Learners will be able to discuss use of last menstrual period, urine and serum pregnancy testing and ultrasound in the diagnosis and dating of pregnancy
- Learners will list causes of first trimester bleeding and discuss management of each (ectopic pregnancy; spontaneous pregnancy loss; threatened abortion; completed abortion)
- Learners will discuss necessary first trimester counseling in terms of diet, prenatal care and genetic testing options.
- Learners will discuss diagnosis and management of hyperemesis gravidarum
- Learners will be able to discuss use of immunizations in pregnancy, including those that are indicated or contraindicated, and windows for administration

**Ante partum Care**
- Learners will list commonly performed testing and surveillance during prenatal care, including time ranges for collection

<table>
<thead>
<tr>
<th>Specific Objective</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Observation Morning Report</td>
<td>Passing Scores on Rotation Evaluation</td>
<td></td>
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</tbody>
</table>
### Curricular Expectations

| Learners will discuss different means for second trimester dating and organ surveys using ultrasound |
| Learners will discuss options for genetic screening for specific genetic conditions, including time ranges and whom to refer to |
| Discuss classification of gestational hypertension and management of hypertensive disorders of pregnancy (PIH, gestational HHT; chronic hypertension and diagnosis management of preeclampsia and eclampsia) |
| Learners will discuss management of common illnesses seen in pregnancy, including URTI, urinary tract infections, vaginal infections (BV, trichomoniasis and other) |

### Labor and Delivery

Learners will be able to discuss:

- Normal progress of labor (normal labor curve)
- Abnormal/protracted labor definitions and management
- Indications and contraindications for vacuum or forceps delivery; version; cesarean delivery
- Active management of the third stage of labor
- Management of retained placenta
- Management of undiagnosed placenta attachment abnormalities or uterine inversion
- Diagnosis and management strategies for the following conditions:
  1. Eclampsia
  2. Fetal Demise
  3. Dysfunctional labor
  4. Non-reassuring fetal status
  5. Prolonged rupture of membranes
  6. Shoulder dystocia
  7. Abnormal lies / presentations

### Obstetrical Prenatal Complications, diagnosis and management

Learners will be able to discuss common management strategies for:

1. Spontaneous miscarriage
   a. Complete
   b. Incomplete
   c. Missed
   d. Septic
2. Other first trimester bleeding
   a. Ectopic pregnancy
   b. Other causes – (Corpus luteum cyst)
3. Rh sensitization: screening and prophylaxis
4. Chronic Hypertension
5. Preeclampsia and Eclampsia
6. Intrauterine growth restriction (IUGR)
7. 3rd trimester bleeding – abruption and previa
8. Premature labor

<table>
<thead>
<tr>
<th>Direct Observation</th>
<th>Passing Scores on Rotation Evaluation</th>
</tr>
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<tbody>
<tr>
<td>Morning Report</td>
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<thead>
<tr>
<th>Direct Observation</th>
<th>Passing Scores on Rotation Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning Report</td>
<td></td>
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<tr>
<td>Curricular Expectations</td>
<td></td>
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</tr>
<tr>
<td>9. Premature Rupture of Membranes</td>
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</tr>
<tr>
<td>10. Abnormal Lies</td>
<td></td>
</tr>
</tbody>
</table>
| 11. Multiple gestation  
  a. Gestational Diabetes and diabetes prior to pregnancy |
| 12. Infectious disease  
  a. TORCH infections  
  b. Sexually transmitted infections  
  i. Chlamydia  
  ii. Gonorrhea  
  iii. Herpes  
  iv. Syphilis  
  v. Human immunodeficiency virus (HIV) |
| 13. Other medical illness during pregnancy |
| 14. Post-term pregnancy |

### Post-Partum care

Learners will be able to:
- Discuss indications and contraindications for breast feeding
- Discuss indications and contraindications for contraception, including medical contraindications
- Discuss screening methods for postpartum depression and demonstrate the ability to use the Edinburgh depression screening tool
- Discuss the importance of family centered maternity care and later family based care provided by family physicians

### PRACTICE-BASED LEARNING AND IMPROVEMENT

**Specific objective**

<table>
<thead>
<tr>
<th>Measurement tool</th>
<th>Expected outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Observation</td>
<td>Morning Report</td>
</tr>
<tr>
<td>Passing Scores on Rotation Evaluation</td>
<td></td>
</tr>
</tbody>
</table>

**Learners will:**
- Demonstrate an ability to use evidence-based medicine to answer clinical questions about management of pregnancy
- Demonstrate the ability to perform an appropriate evidence-based literature search to answer maternity questions
- Participate in a centering pregnancy group workshop
- Demonstrate ability to teach and mentor medical students about family centered maternity care

### INTERPERSONAL AND COMMUNICATION SKILLS

**Specific objective**

<table>
<thead>
<tr>
<th>Measurement tool</th>
<th>Expected outcome</th>
</tr>
</thead>
</table>

**Learners will:**
- Demonstrate acceptable communication skills when interacting with staff, faculty, patients and students

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Curricular Expectations

<table>
<thead>
<tr>
<th>PROFESSIONALISM</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific objective</td>
<td>Measurement tool</td>
<td>Expected outcome</td>
</tr>
<tr>
<td>Learners will:</td>
<td></td>
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</tr>
<tr>
<td>- Discuss and demonstrate how culture, age, language barriers, socioeconomic factors, and related issues can affect pregnancy management and newborn health issues.</td>
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<tr>
<td>- Discuss confidentiality of patient information as it relates to issues of pregnancy and care of newborn.</td>
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<tr>
<td>- Establish mutually respectful working relationships with all members of the maternity care and nursery care team.</td>
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<thead>
<tr>
<th>SYSTEMS-BASED PRACTICE</th>
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<tbody>
<tr>
<td>Specific objective</td>
<td>Measurement tool</td>
<td>Expected outcome</td>
</tr>
<tr>
<td>Learners will:</td>
<td></td>
<td></td>
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<tr>
<td>- Discuss how access to health care impacts perinatal and birth outcomes for both mothers and infants.</td>
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<tr>
<td>- Describe the roles of midwives, nurse practitioners, doulas, obstetricians and family physicians in delivery of U.S. perinatal care.</td>
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<tr>
<td>- Describe how a family-centered approach impacts patient and family experiences with maternity care systems.</td>
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<tr>
<td>- List system safety practices that may improve perinatal and newborn outcomes.</td>
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</tbody>
</table>
Neurology

Schedule: 1 blocks of 4 weeks in R3 year
Location: Baptist Memorial Hospital - Memphis
Clinic: Continuity Clinic 3 days per week

Goals:
1. Achieve competency in the diagnosis and management of neurological conditions commonly encountered in the practice of general internal medicine.
2. Identify conditions requiring either urgent or non-urgent consultation with neurological specialists.

Objectives:
By the end of the Neurology Selective, PGY-3 residents are expected to expand and cultivate skills and knowledge learned during previous training and to achieve the following objectives based on the six general competencies. The resident should have a Milestone equivalent Level 3.5 at end-of-rotation evaluation.

All procedure evaluations should be entered in New Innovations daily, with weekly sign-off by faculty.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Required Skill(s)</th>
<th>Teaching Method(s)</th>
<th>Formative Evaluation Method(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>SPECIALTY SPECIFIC OBJECTIVES</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrate proficiency in obtaining a neurological history and performing a neurological examination.</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feedback &amp; Mini-CEX</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Praise/Concern cards</td>
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<tr>
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<td>End of Rotation Eval</td>
</tr>
<tr>
<td></td>
<td>Distinguish neurological from non-neurological complaints</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feedback &amp; Mini-CEX</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Praise/Concern cards</td>
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<tr>
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<td></td>
<td></td>
<td>End of Rotation Eval</td>
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<tr>
<td></td>
<td>Localize the lesion anatomically</td>
<td>Clinical Teaching Conferences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Formulate a rational differential diagnosis, order appropriate laboratory and diagnostic tests, and effectively manage patients</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feedback &amp; Mini-CEX</td>
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<tr>
<td></td>
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<td></td>
<td>Praise/Concern cards</td>
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<td></td>
<td>End of Rotation Eval</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>SPECIALTY SPECIFIC OBJECTIVES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>Recognize neurological emergencies and call for help when needed</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feedback &amp; Mini-CEX</td>
<td></td>
</tr>
<tr>
<td>Interpret EEG, EMG and NCS, sleep studies, CT, MRI/MRA, myelogram, carotid ultrasound, and angiography reports correctly and apply properly to patient care</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feedback &amp; Mini-CEX</td>
<td></td>
</tr>
<tr>
<td>Demonstrate a basic knowledge of neuroanatomy permitting interpretation of at least non-contrasted and contrasted CT scans</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feedback &amp; Mini-CEX</td>
<td></td>
</tr>
<tr>
<td>Perform lumbar punctures, order the appropriate tests on the CSF, and correctly interpret the results</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feedback &amp; Mini-CEX</td>
<td></td>
</tr>
<tr>
<td>Describe how to perform and interpret the Tensilon test</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feedback &amp; Mini-CEX</td>
<td></td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>SPECIALTY SPECIFIC OBJECTIVES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate scholarship by citing references.</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feed-back, Mini-cex; praise/concern cardsEnd of Rotation Evaluation</td>
<td></td>
</tr>
<tr>
<td>Identify the pathophysiology associated with each clinical condition encountered.</td>
<td>Clinical Teaching Conferences</td>
<td>Direct Feed-back, Mini-cex; praise/concern cardsEnd of Rotation Evaluation</td>
<td></td>
</tr>
</tbody>
</table>
Read and demonstrate knowledge about the following clinical neurological presentations:
- Abnormal speech
- Abnormal vision
- Altered sensation
- Confusion
- Disturbed coordination/gait
- Dizziness
- Headache
- Hearing loss
- Localized pain syndromes
- Loss of consciousness and coma
- Memory impairment
- Seizures
- Sleep disorders
- Tremor
- Weakness - focal and generalized

<table>
<thead>
<tr>
<th>Curricular Expectations</th>
<th>ITE/ABFM Board exam section on Neurology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Teaching</td>
<td>Direct Feed-back, Mini-ex; praise/concern cards</td>
</tr>
</tbody>
</table>

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Orthopedics

Schedule: 2 blocks of 4 weeks each in the R2 year
   First block will be General Orthopedics
   Second block will be Sports Medicine

Location: Baptist Memorial Hospital – Memphis and Ortho Memphis Clinic

Contact: Ortho Memphis

Clinic: Continuity Clinic 2 days per week at Church Health

Goals: Each resident is expected to achieve milestones equivalent level of 3.5 on rotation evaluation and PGY appropriate target score on ITE.

Rotation Specific Medical Knowledge Goals

Procedural Responsibilities:

*** Attending is required to be present for all non-emergent procedures ***

Splinting Techniques
http://hsc.unm.edu/emerg/UNMStudentWebsite/PPT_Presentations/Splinting%20Lecture_files/frame.htm

Casting Techniques http://www.youtube.com/watch?v=exqwise2m8l
Knee Injection http://www.aafp.org/afp/20021015/1497.html
Shoulder Injection http://www.aafp.org/afp/20030315/1271.html
Foot and Ankle Injection http://www.aafp.org/afp/20031001/1356.html

Interpretive Responsibilities:

Shoulder Dislocations http://www.wheelessonline.com/ortho/anterior_instability_of_the_shoulder
Clavicle Fractures http://www.wheelessonline.com/ortho/clavicle_fractions
Nurse Maids Elbow http://www.wheelessonline.com/ortho/nursemaids_elbow_radial_head_subluxation
Humeral Fractures http://www.wheelessonline.com/ortho/fractures_of_the_humerus
Scaphoid Fractures http://www.wheelessonline.com/ortho/scaphoid_scaphoid_fractions
Hand Fractures http://www.wheelessonline.com/ortho/hand_and_metacarpal_fractions
Finger Fracture/Phalangeal Fracture http://www.wheelessonline.com/ortho/phalangeal_fractions
Hip Fractures http://www.wheelessonline.com/ortho/hip_joint_index
Femur Fractures http://www.wheelessonline.com/ortho/femoral_shaft_fractions
### Curricular Expectations

<table>
<thead>
<tr>
<th>Fracture Type</th>
<th>Resource Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tibial/Fibial Fractures</td>
<td><a href="http://wheelessonline.com/ortho/menu_for_the_tibia_tibia_frx">http://wheelessonline.com/ortho/menu_for_the_tibia_tibia_frx</a></td>
</tr>
<tr>
<td>Ankle Fractures</td>
<td><a href="http://wheelessonline.com/ortho/__112">http://wheelessonline.com/ortho/__112</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Knowledge Goals</th>
<th>Resource Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteoarthritis, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/20020301/841.html">http://www.aafp.org/afp/20020301/841.html</a></td>
</tr>
<tr>
<td>Tendon Injury/Overuse, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/20050901/811.html">http://www.aafp.org/afp/20050901/811.html</a></td>
</tr>
<tr>
<td>Use of Braces and Splints in Musculoskeletal Injury</td>
<td><a href="http://www.aafp.org/afp/20070201/342.html">http://www.aafp.org/afp/20070201/342.html</a></td>
</tr>
<tr>
<td>Fracture Classification</td>
<td><a href="http://www.hughston.com/hha/a_14_2_1.htm">http://www.hughston.com/hha/a_14_2_1.htm</a></td>
</tr>
<tr>
<td>Fracture Diagnosis and Management of</td>
<td><a href="http://wheelessonline.com/ortho/trauma_fractures_index">http://wheelessonline.com/ortho/trauma_fractures_index</a></td>
</tr>
<tr>
<td>Cast Types and Maintenance of</td>
<td><a href="http://www.lpch.org/DiseaseHealthInfo/HealthLibrary/orthopaedics/casts.html">http://www.lpch.org/DiseaseHealthInfo/HealthLibrary/orthopaedics/casts.html</a></td>
</tr>
<tr>
<td>Carpal Tunnel Syndrome, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/20030715/265.html">http://www.aafp.org/afp/20030715/265.html</a></td>
</tr>
<tr>
<td>Rotator Cuff Tear/Injury:</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Diagnosis of:</th>
<th>Management of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip Pain/Injuries, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/991015ap/1687.html">http://www.aafp.org/afp/991015ap/1687.html</a></td>
</tr>
<tr>
<td>Hip Fracture, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/20030201/537.html">http://www.aafp.org/afp/20030201/537.html</a></td>
</tr>
<tr>
<td>Hip Pain in Athletes, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/20000401/2109.html">http://www.aafp.org/afp/20000401/2109.html</a></td>
</tr>
<tr>
<td>Knee Pain/Injuries, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/991201ap/2599.html">http://www.aafp.org/afp/991201ap/2599.html</a></td>
</tr>
<tr>
<td>Knee monoarthritis, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/20030701/83.html">http://www.aafp.org/afp/20030701/83.html</a></td>
</tr>
<tr>
<td>Ankle Sprain, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/20061115/1714.html">http://www.aafp.org/afp/20061115/1714.html</a></td>
</tr>
<tr>
<td>Heel Pain, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/20040715/332.html">http://www.aafp.org/afp/20040715/332.html</a></td>
</tr>
<tr>
<td>Toe Fractures, Diagnosis and Management of</td>
<td><a href="http://www.aafp.org/afp/20031215/2413.html">http://www.aafp.org/afp/20031215/2413.html</a></td>
</tr>
<tr>
<td>Lower Extremity Ulcers</td>
<td><a href="http://www.aafp.org/afp/20030815/tips/12.html">http://www.aafp.org/afp/20030815/tips/12.html</a></td>
</tr>
<tr>
<td>Overuse injuries in Childhood/Adolescent Sports</td>
<td><a href="http://www.aafp.org/afp/20060715/293.html">http://www.aafp.org/afp/20060715/293.html</a></td>
</tr>
</tbody>
</table>
Curricular Expectations

Anesthesia-Infiltetive
http://www.aafp.org/afp/20020701/91.html

Anesthesia Topical
http://www.aafp.org/afp/20020701/99.html

Anesthesia Regional
http://www.aafp.org/afp/20040215/896.html

Perioperative Pain Management
http://www.asahq.org/publicationsAndServices/pain.pdf

Management of SBE prophylaxis
http://www.aafp.org/afp/980201ap/taubert.html

DVT diagnosis and treatment
http://www.aafp.org/afp/20040615/2829.html
http://www.aafp.org/afp/20040615/2841.html

Post-Operative Fever
- Wind—pneumonia, atelectasis
- Water—urinary tract infection
- Wound—wound infections
- Wonder drugs—especially anesthesia
- Walking—walking can help reduce deep vein thromboses and pulmonary embolus

Postoperative Medical Care:
http://www.surgical-tutor.org.uk/default-home.htm?intercollegiate.htm~right

Perioperative Medical Care
http://www.surgical-tutor.org.uk/default-home.htm?principles/perioperative.htm~right

Surgical Risk Assessment
Appropriate use of pre-operative tests for elective surgery

Preoperative Antibiotic Guidelines

Improving post-op surgical infections
http://www.ihi.org/HI/Topics/PatientSafety/SurgicalSiteInfections/

Blood Transfusion Guidelines
Curricular Expectations

<table>
<thead>
<tr>
<th>Transfusion Reaction Diagnosis and Management of</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.emedicine.com/emerg/topic603.htm">http://www.emedicine.com/emerg/topic603.htm</a></td>
</tr>
</tbody>
</table>

*Above procedure, interpretive and medical knowledge goals will have specific “check-off” list, to be done by supervising faculty, for both Orthopedic and Sports Medicine rotations, along with standard ACGME Milestone evaluation on New-Innovation.
Outpatient Pediatrics

Schedule:  2 blocks of 4 weeks each in the R2 year
Location:  River City Pediatrics Clinics
Contacts:  Drs. Abbasi, Geiger, Holtzman, Schultz and Stecker
Clinic:  Continuity Clinic 2 days per week at Church Health
Goals:  Each resident is expected to achieve milestones equivalent level of 3.5 on rotation evaluation and PGY appropriate target score on ITE.

Objectives:

• Demonstrate the ability to take an age-appropriate history and perform a physical exam.
• Synthesize an appropriate diagnosis and treatment plan for common pediatric conditions.
• Demonstrate the ability to communicate effectively with the patient, as well as the patient’s family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood.
• Recognize self-limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care.

The resident should demonstrate attitudes that encompass:

1. Empathic concern for the health of the child in the context of the family.
2. The importance of continuity and access to care for prevention of illness.
3. Promotion of healthy lifestyles in children and families.
4. An awareness of the unique vulnerabilities of infants and children that may require special attention, consultation and/or referral.
5. An awareness of social, cultural and environmental factors that impact the health and well-being of infants and children.
6. The importance of educating the public about environmental factors that can adversely affect children and about development of community programs to promote the health of children.
7. The importance of obtaining information about school performance and learning disabilities.

Residents should achieve equivalent of Milestone level 3.5 on end of rotation specific evaluation, and perform at expected level on ITE over Pediatrics

Rotation Specific Medical Knowledge:

Well newborn and child care:

• Recommended schedule and content for examinations from birth to adolescence
• Anticipatory guidance appropriate to age and developmental stage
• Feeding options and variations
• Temperament and behavior
• Developmental stages and milestones
• Developmental screening tests
• Family and social relationships
• Effective parenting
Curricular Expectations

- School readiness
- Sleep problems
- Physical and growth
- Feeding
- Growth and caloric requirements
- Normal growth and variants, including dental development

Prevention and screening:

- Injury prevention
- Motorized vehicles
- Unmotorized vehicles (e.g., bicycles, skates, skateboards, etc.)
- Drowning
- Choking and asphyxiation
- Poisoning
- Firearms
- Falls
- Burns and fire safety
- Child abuse
- Immunization
- Screening
- Anemia
- Lead
- Fluoride
- High-risk children (lipids, TB, other infectious diseases)
- Hypertension
- Other environmental health hazards

Psychological disorders:

- Recognize families with high risk for parent-child interaction, dysfunction or psychiatric problems
- Evaluation, treatment and referral for:
  - Feeding and elimination problems
  - Eating disorders
  - Somatic and sleep disorders
  - Obsessive-compulsive disorders
  - Mood disorders
  - Hyperactive, impulsive and inattentive behaviors
  - Conduct disorders

Social and ethical issues:

- Adoption
- Divorce, separation and death
- Impact of family violence, drug and alcohol abuse
- Child abuse
- Withholding and withdrawing life support
- Nontraditional families
Medical problems of infants and children:

Recognition, management and appropriate referral on the below topics:

Allergic
1. Asthma
2. Atopy
3. Allergic rhinitis

Inflammatory
1. Juvenile rheumatoid arthritis
2. Vasculitis syndromes
3. Kawasaki disease
4. Henoch-Schönlein purpura

Renal and urologic
1. Glomerulonephritis
2. Hematuria and proteinuria
3. Urinary tract infections, including pyelonephritis
4. Vesicoureteral reflux
5. Hypospadias, urethral prolapse, fused labia
6. Enuresis
7. Undescended testis

Endocrine/metabolic and nutritional problems
1. Thyroid disorders
2. Diabetes mellitus, type 1 and type 2
3. Obesity
4. Failure to thrive
5. Abnormal growth patterns (short and tall stature)

Neurologic problems
1. Seizure disorders
2. Headache
3. Syncope
4. Psychomotor delay and cerebral palsy
5. Tics and movement disorders

Common skin problems
1. Atopic dermatitis
2. Viral exanthema and enanthema
3. Bites and stings
4. Bacterial and fungal infections
5. Lice and scabies
6. Diaper rash
7. Acne
8. Urticaria and erythema multiforme
9. Burns

**Musculoskeletal problems**
1. Clubfoot
2. Developmental dysplasia of the hip
3. Rotational problems and gait abnormalities
4. In- and out-toeing
5. Metatarsus adductus
6. Medial tibial torsion
7. Femoral anteverision
8. Scoliosis (idiopathic or acquired)
9. Aseptic necrosis of the femoral head (Legg-Calvé Perthes disease)
10. Slipped capital femoral epiphysis
11. Common sprains, dislocations and fractures
12. Limping

**Gastrointestinal problems**
1. Gastroenteritis (viral and bacterial)
2. Constipation and encopresis
3. Hepatitis
4. Colic
5. Gastroesophageal reflux
6. Food intolerance and malabsorption
7. Pyloric stenosis
8. Intussusception
9. Appendicitis and peritonitis
10. Recurrent and chronic abdominal pain
11. Hernia
12. Bilious emesis
13. Hematemesis
14. Hematochezia

**Cardiovascular problems**
1. Congenital heart disease and valvular disease
2. Evaluation of heart murmurs
3. Chest pain
4. Hypertension

**Respiratory tract problems**
1. Viral upper respiratory tract infections
2. Reactive airway disease and asthma
3. Cystic fibrosis
4. Bronchiolitis
5. Foreign body aspiration
6. Viral or bacterial pneumonia
7. Pertussis
Curricular Expectations

8. Tonsillitis, pharyngitis, sinusitis
9. Epiglottitis versus croup
10. Epistaxis
11. Bacterial tracheitis
12. Snoring
13. Obstructive sleep apnea

Ear problems
1. Otitis media (acute and with effusion)
2. Otitis externa
3. Hearing loss
4. Wax and foreign body in ear canal

Eye problems
1. Amblyopia
2. Strabismus
3. Lacrimal-duct stenosis
4. Decreased visual acuity
5. The red eye
6. Congenital cataracts
7. Dacryocystitis
8. Coloboma

Other serious infections
1. Sepsis and sepsis syndromes
2. Meningitis and encephalitis
3. Invasive streptococcal and staphylococcal disease
4. Osteomyelitis
5. Human immunodeficiency virus (HIV)

Lymphatic problems
1. Reactive lymphadenopathy
2. Cervical adenitis

Childhood malignancies
1. Lymphoma
2. Neuroblastoma
3. Wilms’ tumor
4. Leukemia

Resident is expected to access evidenced based guidelines and recent literature as references for attaining competence in the above objectives, which will also be experienced during longitudinal Family Medicine continuity-of-care clinic. Competency will be evaluated by oral presentations to preceptor, formal New Innovation evaluations by preceptors and nursing staff, and ITE scores.
Rheumatology

Schedule: 1 blocks of 4 weeks in the R3 year
Location: Baptist Memorial Hospital – Memphis
Clinic: Continuity Clinic 3 days per week at Church Health
Goals: Each resident is expected to achieve milestones equivalent level of 3.5 on rotation evaluation and PGY appropriate target score on ITE.

The primary care physician commonly encounters musculoskeletal complaints. The overall goals of this rotation are to provide the second or third year resident with a solid foundation for evaluating and treating the patient with such complaints. Specifically, the resident will learn to:

1. Effectively evaluate and treat (at a level appropriate for Family Physician) patients with musculoskeletal syndromes and connective tissue diseases commonly seen in the outpatient setting;
2. Identify those patients who would benefit from consultative care, including care from rheumatologists, surgeons, and physical and occupational therapists; and
3. Assess hospitalized patients with rheumatic disease and provide recommendations for care in the context of their underlying disease and rheumatic medications. Additionally, the rotation will provide opportunities to foster learner-centered, learner-directed education.

Objectives:
By the end of the Rheumatology Subspecialty experience, PGY-3 residents are expected to expand and cultivate skills and knowledge learned during previous training and to achieve the following objectives based on the six general competencies. The resident should attain Milestone Equivalent Level 3.5 on end-of-rotation evaluation.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Required Skill(s)</th>
<th>Teaching Method(s)</th>
<th>Formative Evaluation Method(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>SPECIALTY SPECIFIC OBJECTIVES</td>
<td>Assess the patient with the following rheumatologic complaints:</td>
<td>Clinical Teaching Conferences Reading List Case Presentations</td>
</tr>
</tbody>
</table>
### Curricular Expectations

**Evaluate, diagnose, and manage patients with the following connective tissue diseases who have typical clinical findings (history, physical, lab) and to design an appropriate treatment regimen for them (knowledge base):**

- **Common arthritides**
  - Rheumatoid arthritis
  - Osteoarthritis
  - Spondyloarthropathies
  - Crystal-induced arthropathies

- **Systemic Rheumatic diseases**
  - Systemic lupus erythematosus
  - Inflammatory myopathies
  - Systemic sclerosis and mixed connective tissue disease

- **Vasculopathies**
  - Giant cell arteritis and polymyalgia rheumatica
  - Differential diagnosis of vasculitis fibromyalgia

<table>
<thead>
<tr>
<th>Medical Knowledge</th>
<th>SPECIALTY SPECIFIC OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recognize the indications for and potential side effects of pharmacologic agents used in the treatment of rheumatic disease including NSAIDs, hydroxychloroquine, sulfasalazine, gold, methotrexate, azathioprine, TNF inhibitors, leflunomide, corticosteroids, colchicines, probenecid and allopurinol</strong></td>
<td>Clinical Teaching Conferences Reading List Case Presentations Mini-CEX Praise/Concern cards End-of-Rotation Eval</td>
</tr>
</tbody>
</table>
| **Perform the following:**
  - Obtain a complete history and perform a thorough musculoskeletal examination on patients suspected of having a rheumatic disease
  - Appropriately perform joint aspiration of large synovial joints and be able to interpret synovial fluid analyses.
  - Interpret imaging examinations, including plain radiographs and MRI.
  - Be able to inject
    - the shoulder, elbow, wrist, or knee joints
    - the subacromial, olecranon, trochanteric, and anserine bursae
    - the carpal tunnel | Clinical Teaching Conferences Reading List Case Presentations Mini-CEX Praise/Concern cards End-of-Rotation Eval |
<table>
<thead>
<tr>
<th>Practice Based Learning and Improvement</th>
<th>Interpersonal and Communication Skills</th>
<th>Professionalism</th>
<th>Systems-Based Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquire an understanding that many of the rheumatic diseases develop over lengthy periods of time, and thus identify strategies for working with patients with incomplete or partially defined conditions</td>
<td>Describe the chronic nature of many rheumatic diseases, and their impact on patient/family quality of life including work, leisure/social, psychologic, sexual domains</td>
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<tr>
<td></td>
<td></td>
<td>Speciality Specific Objectives</td>
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<td>See General Objectives for a comprehensive list.</td>
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<td>Speciality Specific Objectives</td>
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<td>Speciality Specific Objectives</td>
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<tr>
<td></td>
<td></td>
<td>See General Objectives for a comprehensive list.</td>
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</tr>
</tbody>
</table>
Surgery

Schedule: 1 blocks of 4 weeks in the R2 year
Location: Baptist Memorial Hospital – Memphis
Contact: Lee Morisy, MD
Clinic: Continuity Clinic 2 days per week
Goals: Each resident is expected to achieve milestones equivalent level of 2.5 on rotation evaluation and PGY appropriate target score on ITE.

Rotation Specific Procedural Goals (may be part of longitudinal surgical rotation)

Procedural Responsibilities

**Attending is required to be present for all non-emergent procedures:

- Surgical First Assist
- Suturing Techniques

Contains detailed diagrams of surgical knots, techniques of ties, and has available video demonstrations.

- Stapling Techniques
- Steri-strip Techniques
  - http://solutions.3m.com/wps/portal/3M/en_US/SkinHealth/brands/steri-strip/application/

Detailed instructions and video on a variety of incision types and surgical applications.

- Incision and Drainage
- Chest Tubes
- Central Lines
- PICC Lines
- EGD (may be part of elective rotation for procedures)
  - The endoscopy learning center: http://www.gastrolab.net/lc1.htm
Colonoscopy
The endoscopy learning center:  http://www.gastrolab.net/lc1.htm


Nasogastric Tube Insertion

Interpretive Responsibilities

Chest x-ray

Pneumothorax

ET tube/feeding tube placement x-ray

EKG/Rhythm Strips

Lab Values, related to acute abdomen

Abdominal x-ray Series

Free Air:


Small Bowel Obstruction


Large Bowel Obstruction


GI Film Case Studies

Rotation Specific Medical Knowledge Goals:

<table>
<thead>
<tr>
<th>Medical Knowledge</th>
<th>Overall Goal: Become competent assessing patients for possible surgery.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Objective</td>
<td>Measurement Tool</td>
</tr>
<tr>
<td>Cancer Staging TNM method</td>
<td>Direct Observation</td>
</tr>
<tr>
<td>Acute Abdomen (Diagnosis of and treatment of)</td>
<td>Direct Observation</td>
</tr>
<tr>
<td>Appendicitis Diagnosis and Management</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20050101/71.html">http://www.aafp.org/afp/20050101/71.html</a></td>
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<tr>
<td><a href="http://www.aafp.org/afp/991101ap/207.html">http://www.aafp.org/afp/991101ap/207.html</a></td>
<td></td>
</tr>
<tr>
<td>Abdominal Wall Pain Diagnosis and Management</td>
<td>Direct Observation</td>
</tr>
<tr>
<td>Jaundice in the Adult Patient Diagnosis and Management</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20040115/299.html">http://www.aafp.org/afp/20040115/299.html</a></td>
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<tr>
<td>Acute Pancreatitis Diagnosis and Management</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20000701/164.html">http://www.aafp.org/afp/20000701/164.html</a></td>
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<tr>
<td>Chronic Pancreatitis Diagnosis and Management</td>
<td>Direct Observation</td>
</tr>
<tr>
<td>Management of Gallstones</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20050815/637.html">http://www.aafp.org/afp/20050815/637.html</a></td>
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</tr>
<tr>
<td>Ileus Newborn</td>
<td>Direct Observation</td>
</tr>
<tr>
<td>Small Bowel Obstruction Diagnosis and Management</td>
<td>Direct Observation</td>
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<tr>
<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>Large Bowel Obstruction Diagnosis and Management</td>
<td>Direct Observation</td>
</tr>
<tr>
<td>Colon Cancer Screening Guidelines</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><a href="http://www.ahrq.gov/clinic/3rduspstf/colorectal/colorr.htm">http://www.ahrq.gov/clinic/3rduspstf/colorectal/colorr.htm</a></td>
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<tr>
<td>Colon Polyp Types and Management</td>
<td>Direct Observation</td>
</tr>
<tr>
<td><a href="http://www.aafp.org/afp/20000315/1759.html">http://www.aafp.org/afp/20000315/1759.html</a></td>
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<tr>
<td>Diverticular Disease Diagnosis and Treatment:</td>
<td>Direct Observation</td>
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<tr>
<td><a href="http://www.aafp.org/afp/20051001/1229.html">http://www.aafp.org/afp/20051001/1229.html</a></td>
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<td>Breast Cancer Screening Guidelines</td>
<td>Direct Observation</td>
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<tr>
<td>Breast Cancer Management</td>
<td>Direct Observation</td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>Direct Observation</td>
</tr>
<tr>
<td>Vascular Surgery Indications (Carotids, aneurysms, PVOD)</td>
<td>Direct Observation</td>
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<tr>
<td><a href="http://www.aafp.org/afp/20070101/85.html">http://www.aafp.org/afp/20070101/85.html</a></td>
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<td>Lower Extremity Ulcers</td>
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<td><a href="http://www.aafp.org/afp/20030815/tips/12.html">http://www.aafp.org/afp/20030815/tips/12.html</a></td>
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<tr>
<td>Hernia Management and Treatment Groin</td>
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<td><a href="http://www.aafp.org/afp/990101ap/143.html">http://www.aafp.org/afp/990101ap/143.html</a></td>
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<tr>
<td>Curricular Expectations</td>
<td>Direct Observation</td>
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<td><a href="http://www.nlm.nih.gov/medlineplus/tutorials/inguinalhernia/htm/index.htm">http://www.nlm.nih.gov/medlineplus/tutorials/inguinalhernia/htm/index.htm</a></td>
<td>Direct Observation</td>
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<tr>
<td>Incisional</td>
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<td>Wound Care</td>
<td><a href="http://www.emedicine.com/med/topic2754.htm">http://www.emedicine.com/med/topic2754.htm</a></td>
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<td><a href="http://www.surgical-tutor.org.uk/default-home.htm?core/preop2/healing.htm~right">http://www.surgical-tutor.org.uk/default-home.htm?core/preop2/healing.htm~right</a></td>
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<td><a href="http://www.medicaledu.com/phases.htm">http://www.medicaledu.com/phases.htm</a></td>
</tr>
<tr>
<td>Wound Etiology/Types of Ulcers</td>
<td><a href="http://www.medicaledu.com/etiology.htm">http://www.medicaledu.com/etiology.htm</a></td>
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<tr>
<td>Ulcer Staging</td>
<td><a href="http://www.medicaledu.com/staging.htm">http://www.medicaledu.com/staging.htm</a></td>
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<tr>
<td>Clinical Guidelines for Wound Ulcer Treatment</td>
<td><a href="http://www.medicaledu.com/ahcpr.htm">http://www.medicaledu.com/ahcpr.htm</a></td>
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<tr>
<td>Wound Care Products</td>
<td><a href="http://www.medicaledu.com/prodindx.htm">http://www.medicaledu.com/prodindx.htm</a></td>
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<tr>
<td>Wound Care Orders</td>
<td><a href="http://www.medicaledu.com/orders.htm">http://www.medicaledu.com/orders.htm</a></td>
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<tr>
<td>Sources of Wound infections</td>
<td><a href="http://www.surgical-tutor.org.uk/default-home.htm?principles/microbiology/wound_infection.htm~right">http://www.surgical-tutor.org.uk/default-home.htm?principles/microbiology/wound_infection.htm~right</a></td>
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<td>Suture Types</td>
<td><a href="http://www.surgical-tutor.org.uk/default-home.htm?core/preop2/sutures.htm~right">http://www.surgical-tutor.org.uk/default-home.htm?core/preop2/sutures.htm~right</a></td>
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<tr>
<td>Topic</td>
<td>Method</td>
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<td>--------------------------------------------</td>
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<td>Aseptic Technique</td>
<td>Direct Observation</td>
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<td><a href="http://www.surgical-tutor.org.uk/default-home.htm?core/preop1/asepsis.htm~right">http://www.surgical-tutor.org.uk/default-home.htm?core/preop1/asepsis.htm~right</a></td>
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<td>Surgical Drains</td>
<td>Direct Observation</td>
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<td><a href="http://www.surgical-tutor.org.uk/default-home.htm?core/preop1/surgical_drains.htm~right">http://www.surgical-tutor.org.uk/default-home.htm?core/preop1/surgical_drains.htm~right</a></td>
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<tr>
<td>Anesthesia-Infiltrative</td>
<td>Direct Observation</td>
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<td><a href="http://www.aafp.org/afp/20020701/91.html">http://www.aafp.org/afp/20020701/91.html</a></td>
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<td>Anesthesia Topical</td>
<td>Direct Observation</td>
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<td><a href="http://www.aafp.org/afp/20020701/99.html">http://www.aafp.org/afp/20020701/99.html</a></td>
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<td>Anesthesia Regional</td>
<td>Direct Observation</td>
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<td><a href="http://www.aafp.org/afp/20040215/896.html">http://www.aafp.org/afp/20040215/896.html</a></td>
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<td>Perioperative Pain Management</td>
<td>Direct Observation</td>
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<td><a href="http://www.asahq.org/publicationsAndServices/pain.pdf">http://www.asahq.org/publicationsAndServices/pain.pdf</a></td>
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<tr>
<td>Management of SBE prophylaxis</td>
<td>Direct Observation</td>
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<td><a href="http://www.aafp.org/afp/980201ap/taubert.html">http://www.aafp.org/afp/980201ap/taubert.html</a></td>
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<tr>
<td>DVT diagnosis and treatment</td>
<td>Direct Observation</td>
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<td><a href="http://www.aafp.org/afp/20040615/2829.html">http://www.aafp.org/afp/20040615/2829.html</a></td>
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<td><a href="http://www.aafp.org/afp/20040615/2841.html">http://www.aafp.org/afp/20040615/2841.html</a></td>
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<tr>
<td>Post-Operative Fever</td>
<td>Direct Observation</td>
</tr>
<tr>
<td>Wind--pneumonia, atelectasis</td>
<td></td>
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<tr>
<td>Water--urinary tract infection</td>
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<tr>
<td>Wound--wound infections</td>
<td></td>
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<tr>
<td>Wonder drugs--especially anesthesia</td>
<td></td>
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<tr>
<td>Walking--walking can help reduce deep Vein</td>
<td></td>
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<tr>
<td>thromboses and pulmonary embolus</td>
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<tr>
<td>Post operative Medical Care:</td>
<td>Direct Observation</td>
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<tr>
<td><a href="http://www.surgical-tutor.org.uk/default-home.htm?intercollegiate.htm~right">http://www.surgical-tutor.org.uk/default-home.htm?intercollegiate.htm~right</a></td>
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<tr>
<td>Perioperative Medical Care</td>
<td>Direct Observation</td>
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<td><a href="http://www.surgical-tutor.org.uk/default-home.htm?principles/perioperative.htm~right">http://www.surgical-tutor.org.uk/default-home.htm?principles/perioperative.htm~right</a></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-op cardiac assessment</th>
<th>Direct Observation</th>
<th>Milestone Level 3-4 on rotation end evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://acc.org/qualityandscience/clinical/guidelines/periob/update/periupdate_index.htm">http://acc.org/qualityandscience/clinical/guidelines/periob/update/periupdate_index.htm</a></td>
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<tr>
<td>Palm Program for Cardiac Clearance</td>
<td>Chart Review</td>
<td>Milestone Level 3-4 on rotation end evaluation</td>
</tr>
<tr>
<td><a href="http://www.statcoder.com/cardiac1.htm">http://www.statcoder.com/cardiac1.htm</a></td>
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<table>
<thead>
<tr>
<th>Surgical Risk Assessment</th>
<th>Direct Observation</th>
<th>Milestone Level 3-4 on rotation end evaluation</th>
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</thead>
<tbody>
<tr>
<td>Appropriate use of pre-operative tests for elective surgery</td>
<td>Chart Review</td>
<td>Milestone Level 3-4 on rotation end evaluation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgical Preps</th>
<th>Direct Observation</th>
<th>Milestone Level 3-4 on rotation end evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel</td>
<td>Chart Review</td>
<td>Milestone Level 3-4 on rotation end evaluation</td>
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<thead>
<tr>
<th>Preoperative Antibiotic Guidelines</th>
<th>Direct Observation</th>
<th>Milestone Level 3-4 on rotation end evaluation</th>
</tr>
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<tbody>
<tr>
<td>Improving post-op surgical infections</td>
<td>Chart Review</td>
<td>Milestone Level 3-4 on rotation end evaluation</td>
</tr>
<tr>
<td><a href="http://www.ihi.org/IHI/Topics/PatientSafety/SurgicalSiteInfections/">http://www.ihi.org/IHI/Topics/PatientSafety/SurgicalSiteInfections/</a></td>
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</table>

<table>
<thead>
<tr>
<th>Parenteral Nutrition Management</th>
<th>Direct Observation</th>
<th>Milestone Level 3-4 on rotation end evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete this tutorial</td>
<td>Chart Review</td>
<td>Milestone Level 3-4 on rotation end evaluation</td>
</tr>
<tr>
<td><a href="http://www.csun.edu/~cjh78264/parenteral/introductio%22n.html">http://www.csun.edu/~cjh78264/parenteral/introductio&quot;n.html</a></td>
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<table>
<thead>
<tr>
<th>Blood Transfusion Guidelines</th>
<th>Direct Observation</th>
<th>Milestone Level 3-4 on rotation end evaluation</th>
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</table>

<table>
<thead>
<tr>
<th>Transfusion Reaction Diagnosis and Management of</th>
<th>Direct Observation</th>
<th>Milestone Level 3-4 on rotation end evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.emedicine.com/emerg/topic603.htm">http://www.emedicine.com/emerg/topic603.htm</a></td>
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</tbody>
</table>
Curricular Expectations

Surgical Subspecialty: (ENT, Ophth, Uro, Oral Health and Rehab)

Schedule:
- 2 blocks of 4 weeks each in the R3 year
  - First block will be Surgical Subspecialties
  - Second block will be Surgical Subspecialties and Rehabilitation Medicine

Location: Baptist Memorial Hospital – Memphis

Clinic: Continuity Clinic 3 days per week

Goals:
Each resident is expected to achieve milestones equivalent level of 3.5 on rotation evaluation and PGY appropriate target score on ITE.

*** Attending is required to be present for all non-emergent procedures ***

General Procedural Responsibilities:

Slit Lamp Examination
Foreign body removal from eye
Otoscope examination
Foreign body removal from ear
Nasolaryngoscopy
Audiology testing [http://www.aafp.org/afp/20000501/2749.html](http://www.aafp.org/afp/20000501/2749.html)
Cerumen removal—with loop and/or irrigation
Placement of ear wick
Urinary catheterization
Urodynamic studies [http://www.aafp.org/afp/980600ap/weiss.html](http://www.aafp.org/afp/980600ap/weiss.html)

General Interpretive Responsibilities:

Sinus Films/CT
Glaucoma indicators/pressure reading
Uro-dynamic Studies [http://www.aafp.org/afp/980600ap/weiss.htm](http://www.aafp.org/afp/980600ap/weiss.htm)
Tympanogram [http://www.aafp.org/afp/20041101/1713.html](http://www.aafp.org/afp/20041101/1713.html)
### Rotation Specific Medical Knowledge Goals:

<table>
<thead>
<tr>
<th>Urology Specific Knowledge Based Competency</th>
<th>Measurement Tool</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands growth and development of male anatomy</td>
<td>Direct observation</td>
<td>Satisfactory course evaluation (Milestone Level 3-4)</td>
</tr>
<tr>
<td>Dysuria work up</td>
<td>*Direct Observation</td>
<td>Satisfactory Course Evaluation</td>
</tr>
<tr>
<td>Acute Scrotum</td>
<td>*Direct Observation</td>
<td>Satisfactory Course Evaluation</td>
</tr>
<tr>
<td>Diagnosis and treatment of STD’s</td>
<td>*Direct Observation</td>
<td>Satisfactory Course Evaluation</td>
</tr>
<tr>
<td>Diagnosis and treatment of Epididymitis</td>
<td>*Direct Observation</td>
<td>Satisfactory Course Evaluation</td>
</tr>
<tr>
<td>Diagnosis and treatment of Orchitis</td>
<td>*Direct Observation</td>
<td>Satisfactory Course Evaluation</td>
</tr>
<tr>
<td>Diagnosis and treatment of Prostatitis</td>
<td>*Direct Observation</td>
<td>Satisfactory Course Evaluation</td>
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<tr>
<td>Penile abnormalities</td>
<td>*Direct Observation</td>
<td>Satisfactory Course Evaluation</td>
</tr>
<tr>
<td>Scrotal abnormalities</td>
<td>*Direct Observation</td>
<td>Satisfactory Course Evaluation</td>
</tr>
</tbody>
</table>

**Notes:**
- Audiology results: [http://www.aafp.org/afp/20000501/2749.htm](http://www.aafp.org/afp/20000501/2749.htm)
- Bladder Scans
- PSA results
- Dysuria work up: [http://www.aafp.org/afp/20020415/1589.html](http://www.aafp.org/afp/20020415/1589.html)
- Diagnosis and treatment of Urethritis
- Diagnosis and treatment of Epididymitis
- Diagnosis and treatment of Orchitis: [http://www.aafp.org/afp/980215ap/junnila.html](http://www.aafp.org/afp/980215ap/junnila.html)
- Diagnosis and treatment of Prostatitis: [http://www.aafp.org/afp/20000515/3015.html](http://www.aafp.org/afp/20000515/3015.html)
- Penile abnormalities
  - Peyronies: [http://www.aafp.org/afp/990800ap/549.html](http://www.aafp.org/afp/990800ap/549.html)
  - Epispadias/hypospadias
- Scrotal abnormalities: [http://www.aafp.org/afp/20000515/3015.html](http://www.aafp.org/afp/20000515/3015.html)

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Allergic Rhinitis. Chronic and Seasonal diagnosis and management  
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Head and Neck Symptoms of GERD  
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Oral Health:
Complete “Smiles for Life Modules 1-7” PowerPoint Presentations

Attend Oral Health Clinic at Church Health

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<td>Topic</td>
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<td>11/30/16</td>
<td>Health Systems/ Population Health</td>
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PURPOSE:
The purpose of this policy is to outline the process for Annual Program Evaluations of the ACGME - Baptist Memorial Hospital – Memphis Family Medicine residency program.

POLICY:
A. RESIDENTS: Residents are given the opportunity to evaluate their program and teaching faculty semi-annually. This evaluation is confidential by utilizing online evaluations through New Innovations.
B. FACULTY: The Faculty is given the opportunity to evaluate their program annually. This evaluation is confidential by utilizing online evaluations through New Innovations.
C. PROGRAM DIRECTOR: The Program Director must evaluate and provide feedback to the teaching team at least annually.
D. ANNUAL PROGRAM EVALUATION: The Program has established a Program Evaluation Committee (PEC) whose purpose includes participation in the development of the Program’s curriculum and related learning activities, evaluation of the Program to assess the effectiveness of the curriculum, and identification of actions needed to foster continued program improvement and correction of areas of non-compliance with ACGME standards.

The Graduate Medical Education Committee (GMEC) of Baptist Memorial Hospital requires that the educational effectiveness of a program must be evaluated at least annually in the systematic manner described herein. Representative GMEC personnel must be organized to conduct an annual review of each program. This group must conduct a formal documented meeting annually for this purpose.

Members of the Program Evaluation Committee (PEC) must include at a minimum:
- one faculty member from within the sponsoring institution, but not from within the program being evaluated
- one resident/fellow from within the sponsoring institution, but not from within the program being evaluated
- Additional internal and/or external reviewers and administrators not affiliated with the program as appointed by the GMEC.

In the evaluation process, the group must review the following documents where applicable:
1. ACGME Common Program Requirements
Curricular Expectations

2. ACGME Specialty / Subspecialty Specific Program Requirements
3. ACGME Institutional Requirements
4. Most Recent ACGME Accreditation Letters and Progress Reports
5. Most Recent Annual Program Evaluation Report
6. Most Recent GMEC Special Reviews of the Program if applicable
7. Results from ACGME Resident / Fellow, Faculty Surveys
8. Results from Patient Surveys
9. Annual Performance Data provided by the ACGME
10. Completed APE Self-evaluation report completed and signed by the Program Director

The PEC will draft a report using the approved format in order to evaluate the effectiveness of the program. The report should be given to the Designated Institutional Official (DIO), and BMH-Memphis Chief Medical Officer at least two (2) weeks prior to the next GMEC meeting. That report will be presented at the next GMEC. During that GMEC meeting, the DIO will determine if deficiencies were found and warrant a GMEC Special Program Review. This information will be recorded in the GMEC minutes.

See GMEC Special Review Policy for additional information on this procedure.

Annual Program Evaluation / Internal Review Template to follow

The remainder of this page has been left intentionally blank.
**Program Name:**

**Academic Year ending date:**

**Program Director:** Name __________________________ Email Address __________________________ Phone __________________________

**Department Chair:** Name __________________________ Email Address __________________________ Phone __________________________

**Assoc. Prog Dir:** Name __________________________ Email Address __________________________ Phone __________________________

**Prog Coordinator:** Name __________________________ Email Address __________________________ Phone __________________________

<table>
<thead>
<tr>
<th>TRAINEES</th>
<th>PGY-1</th>
<th>PGY-2</th>
<th>PGY-3</th>
<th>PGY-4</th>
<th>PGY-5</th>
<th>PGY-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved</td>
<td></td>
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<tr>
<td>Filled</td>
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<thead>
<tr>
<th>Other Learners</th>
<th>Total # last 12 months</th>
<th>Maximum # at any time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents from other programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical students</td>
<td></td>
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<tr>
<td>Subspecialty fellows</td>
<td></td>
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</tr>
</tbody>
</table>

**Policies:**

Do you have:  

1. Written supervision policy for each activity and PGY-level?  
2. Written specialty-specific selection guidelines?  
3. Documentation of prior training for each trainee?
### Clinical Competency Committee (CCC):

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the Program have a CCC?</td>
<td></td>
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<tr>
<td>2.</td>
<td>Is the Program Director also the Chair of the CCC?</td>
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<td>3.</td>
<td>Has the CCC met to evaluate appropriate individual trainee progression?</td>
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<td>4.</td>
<td>Is the CCC comprised of faculty from all rotation sites and services?</td>
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<td>5.</td>
<td>Does the CCC provide feedback and mentorship to trainees?</td>
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<td>6.</td>
<td>Is the CCC satisfied with current 360° evaluation methods?</td>
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<td>7.</td>
<td>Do all CCC members participate in at least 50% of all discussions?</td>
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<td>8.</td>
<td>Does the CCC evaluate the Supervision Policy at least annually?</td>
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<td>9.</td>
<td>Does the CCC evaluate the trainee schedule at least annually?</td>
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<td>10.</td>
<td>Does the CCC evaluate the curriculum / goals &amp; objectives at least annually?</td>
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</tbody>
</table>

### Changes:

Describe any changes that have occurred since the previous APE/IR.

### Performance:

Discuss briefly Trainee Performance during the past twelve (12) months:

- **In-Service Exams (include "on target" expectations)**

- **Resident Portfolios**
Curricular Expectations

- Case Logs

- Radiation Safety Training

- Conference Presentations

- Minimal participation requirements and compliance for residents in each of the following activities:
  a. Organized Clinical Discussions
  b. Patient Rounds
  c. Journal Clubs
Curricular Expectations

d. Daily Conferences

- Quality & Safety Committee Attendance and Interaction

- Duty Hour compliance

Research:
During the last twelve (12) months:

| Number of Accepted Publications by Trainees |
| Number of Regional Presentations by Trainees |
| Number of National Presentations by Trainees |

Describe any additional resident research outcomes:

Quality & Safety:
Describe trainee involvement in quality & safety initiatives:
Discuss Program Quality & Improvement efforts resulting from the most recent Program Evaluation and Resident Surveys

Discuss trainee, faculty, and program compliance with established policies and guidelines including:

1. Supervision
2. Transitions in Care
3. Evaluation (360° Trainee, Faculty, Program, Annual)
4. Duty Hours
5. Moonlighting
Curricular Expectations

Graduate Performance:
Discuss Board Scores including pass, fail, and condition (if applicable) percentages

Discuss employment, fellowship, and other paths taken

Faculty Development:
Describe Faculty Development activities for the previous twelve (12) months

Participating Sites:
List the Participating Sites hosting required rotational assignments and the date of the most recent Program Letter of Agreement (PLA) for each. Identify if the PLA is in compliance with all Common Program Requirements.

<table>
<thead>
<tr>
<th>Participating Site</th>
<th>Date of PLA</th>
<th>In Compliance (Yes/No)</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>
### Program Director (PD) / Faculty:

1. Is there one Program Director with authority and accountability for this program?

2. Is the PD qualified for this position per ACGME RC standards?

3. What is the Core Faculty to Resident ratio?

4. Is the Core Faculty qualified per ACGME RC standards?

5. How often does each Core Faculty member participate / present in organized clinical discussions, rounds, journal clubs, and conferences?

6. What percentage of Core Faculty has contributed to one of more of the following (peer-reviewed funding; publication of original research or review articles in peer-reviewed journals or textbook chapter(s); publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or participation in national committees or educational organizations)?

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**Attach to this Document:**

- Current Program Letters of Agreement
- Goals & Objectives (may include ACGME competencies and Milestones) based on educational level of progression for each rotation
- Individualized resident evaluation form for ACGME Competencies and Milestones if not included above
- Didactic Calendar for the past year including identification of Fatigue Mitigation and Impaired Physician presentations
- Most recent Program and Faculty Evaluation Summaries
- Most recent Program Evaluation of the Curriculum (ACGME Common Program Requirements V.C.1.)
- Action Plan, if applicable, resulting from previous Annual Program Evaluation, Program Self-Evaluation, Resident Survey, or GMEC Special Review
- Current Program Specific Supervision Guidelines if applicable