Family Medicine
Resident Handbook

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This handbook is provided to prospective and current residents for information and guidance. The main purpose is to describe our residency and address common questions concerning our program and it will be updated annually to ensure accuracy. Please let us know if you have suggestions for things to include. This handbook is not meant to supersede SRH policies- however sometimes residency training requirements from ACGME do dictate differences. Please refer to your resident contract first, then the resident handbook, and ask for clarification if there's any confusion.

Contents

Section 1— Sponsoring Institution

Overview of Skagit Regional Health

Skagit Regional Health (SRH) is a healthcare leader in northwest Washington state, providing advanced technology and high quality, patient-centered care to the people of Skagit, Island and north Snohomish Counties. The SRH system includes two inpatient facilities, Skagit Valley Hospital in Mount Vernon and Cascade Valley Hospital in Arlington, as well as approximately two dozen outpatient clinics in our three county service area. Descriptions of each facility and the services offered can be found on the SRH website Home (skagitregionalhealth.org).

Meeting Basic Needs

Skagit Valley Hospital (SVH) provides two call rooms for residents to permit rest during night float. A telephone and computer are present in the call rooms with restroom and shower facilities nearby. When on OB, if available, you are able to use a clean patient room to rest and document as needed.

If a resident is unsafe to drive home safely or road conditions are poor (snow/ ice) – safe options provided are the GME and other SRH call rooms, a couch in the resident lounge, and an air mattress which could be used in the didactics room for privacy overnight.

In order to provide a supportive environment for breastfeeding, a resident may use the call rooms or the lactation room in the hospital. For milk storage, the fridge in the GME kitchen and the FM Residency Clinic kitchens are both available. Breaks will be available as needed (generally one patient is blocked in clinic schedules in the mid-morning and mid-afternoon), and most didactic presentations can be viewed via Zoom. You are also welcome to join didactics and meetings if you are utilizing hands-free pumping devices.

SVH has a Bistro and coffee shop for food purchase, and some food is provided in the resident lounge for residents working nights and weekends. A food allowance is provided for residents' personal use in the Bistro during daytime work hours. (This does not extend to the privately-owned coffee shop.)

Security Services are provided 24 hours per day, 7 days per week. The Hospital perimeter envelope will be unlocked at 0530 and locked at 2130 seven days per week. A security officer is on site in the Emergency Department 7 days per week, and holidays, from 1400 until 0600. The on-duty Nursing Supervisor and the Security Services Manager or designee coordinate all security activities within the hospital. Public access into the hospital after business hours will be via the Emergency Department entrance only. Residents may enter any exterior door by means of a badge-swipe at doors with card readers.

SRH uses Epic EHR. The Graduate Medical Education (GME) wing includes didactic rooms, library area, resident lounge, break room, locker rooms, call room, and residency staff and faculty offices. There are multiple conference rooms and an IT training room available within the hospital by reservation.

FM Residency Continuity Clinic

Residents are the Primary Care Physicians for their own individual panels of patients at the SRH Family Medicine Residency Clinic, which is located across the street from the hospital. The clinic includes a waiting area, 8 examination rooms, procedure room, faculty preceptor offices, work stations for MA/ physician pairs, and a break room.

There are currently a part time psychiatrist and a patient navigator that share clinic space with the FM Residency. The psychiatrist sees patients part time in clinic and works in the inpatient mental health unit the

rest of the time. The patient navigator is part of a hub-and-spoke program with SRH and Ideal Options, a local partner organization, to help our patients facing needs related to substance use disorders and connecting them with local resources.

Library and Educational Resources

SRH provides a library and coordinator to assist residents. Library resources and services are reviewed annually by the library coordinator, who submits a report to the GME Committee. Library resources include electronic Medline, UpToDate, medical dictionaries, major indexes, current textbooks and journals, patient education materials, practice guidelines, document services, and print materials. Some journals are available in the resident lounge, and books in the clinic.

The FM residents also have library privileges through Pacific Northwest University of Health Sciences College of Osteopathic Medicine (PNWU) and University of Washington School of Medicine (UW) through the FM Residency Network (FMRN). These provide additional electronic access to journals and professional publications as well as extensive research data through the UW Care Provider Toolkit Care Provider Toolkit | UW Health Sciences Library.

Residents and faculty also have access to research scientists at PNWU and UW FMRN for assistance with any scholarly projects they are working on.

Quality Measures

Skagit Regional Health is committed to providing safe, quality patient care and embraces transparency in public reporting of quality measurements and national scorecards to promote education and awareness among consumers. SRH voluntarily provides quality and pricing data to initiatives including the Washington State Hospital Association's Quality Measures Website, the Centers for Medicare & Medicaid Services' Hospital Compare website and participates in the Institute for Healthcare Improvement's 100,000 Lives and 5 Million Lives campaigns. Residents receive both inpatient and outpatient quality reports, and individual quality dashboards for their patient panels.

Accreditations and Memberships

DNV Healthcare - SRH is accredited by DNV Healthcare under the authority of the US Centers for Medicare and Medicaid Services. Our facilities are compliant with the ISO 9001 Quality Management System. DNV (Det Norske Veritas) is an independent foundation with the purpose of safeguarding life, property, and the environment.

The American College of Surgeons Commission on Cancer - The hospital has been certified by the American College of Surgeons since 1975, which acknowledges the hospital's high quality multidisciplinary cancer care program that meets rigorous compliance standards.

The American Hospital Association - SRH is a member of this national organization founded in 1898 that represents and serves not only nearly 5,000 hospitals but also health care networks, patients and communities. The AHA serves as an educational resource on health care issues and trends for leaders at SRH.

The Washington State Hospital Association - WSHA is a membership organization representing community hospitals and several health-related organizations. The association provides issues management and analysis, information, advocacy and other services.

Seattle Cancer Care Alliance – The SRH Cancer Care Center is honored to be selected as just the second network affiliate of the Seattle Cancer Care Alliance, a partnership of three world-renowned cancer programs, Fred Hutchinson Cancer Research Center, UW Washington Medicine, and Children's Hospital and Regional Medical Center. As a network affiliate since 2005, our providers and patients benefit from the resources, research, clinical trials and treatment options of the Seattle Cancer Care Alliance while in treatment here at the Cancer Care Center in Mount Vernon.

Residency Accreditation

ACGME (Accreditation Council for Graduate Medical Education) since July 2017, with Osteopathic Recognition since July 2018. We accept both DO and MD residents, students, and faculty. Formerly an AOA (American Osteopathic Association)-accredited program 2011- 2019, with our first residents in 2012. SRH is our "Sponsoring Institution" and currently sponsors both FM and IM residency programs.

Section 2— People

Core Faculty (Full-time Faculty)

Julie Merriam, DO	Board Certified –AOBFP
FM Program Director	National Institute of Program Director Development Fellowship 2017-18 Email: jmerriam@skagitregionalhealth.org Cell: 253-579-3765
Allison Abresch Meyer, DO Associate PD FM Director of Osteopathic Education Core FM Faculty	Board Certified –AOBFP, AOBNMM UC Davis Primary Care Psychiatry Fellowship 2022-23 UW FM Faculty Development Fellowship 2018-19 Email: AAbresch-Meyer@skagitregionalhealth.org Cell: 530-304-8892
Eugene Elikh, MD Core FM-OB Faculty	Board Eligible –ABFM UW-Madigan FM Faculty Development Certificate 2025-26 STFM Faculty Development Program 2024-26 Email: yelikh@skagitregionalhealth.org Cell: 509-869-8547
Jeremy Ginoza, DO Core FM Faculty Core OR Faculty	Board Certified –AOBFP, AOBNMM, ABFM UW FM Faculty Development Fellowship 2019-20 Email: jginoza@skagitregionalhealth.org Cell: 760-822-1386
Naomi Hoyle, MD Core FM-OB Faculty	Board Certified –ABFM UW FM Faculty Development Fellowship 2025-26 Email: nhoyle@skagitregionalhealth.org Cell: 360-503-6437
Emily Kunz Brockman, DO Core FM-OB Faculty Core OR Faculty	Board Certified –AOBFP UW FM Faculty Development Fellowship 2023-24 Email: ekunz@skagitregionalhealth.org Cell: 360-301-1582

Part-time Faculty Clinic Preceptors

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PT FM Faculty
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PT FM (and UC) Faculty &
Nursing Home Director
Board Certified –AOBFP
UW-Madigan FM Faculty Development Certificate 2017-18
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PT FM Faculty
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Residency Administration

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Designated Institutional Official
Board Certified – ABIM, Nephrology
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Cindi Corrales
GME Residency Coordinator
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Residency Clinic Leadership- FM and IM

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Jessica Stratton, RN
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Email: lgross@skagitregionalhealth.org

Frontline Supervisor Phone: 360-814-7559

Residents

Resident Roster: Annual Resident Roster for all FM (and IM) residents with pictures and contact phone numbers is updated each year and distributed widely in the hospital and clinics.

Lead Residents: Formerly known as "Chief" Residents are third year residents peer elected in the second half of their PGY2 to ensure the opportunity to work with the outgoing leads for continuity with any active projects. These positions have a small monthly stipend. The Co-Leads set a high standard of professionalism and communication. They attend the FM Lead Residents' conference at UW in the spring and fall to help develop professional leadership skills and network with other resident leaders in the UW FM Residency Network.

The Leads plan the call schedules, lead resident meetings, represent their peer group on the GMEC (Graduate Medical Education Committee), and are members of our FM Program Evaluation Committee. The Leads will also assist in review of policies and procedures, preparation for inspections and internal reviews, and organizing resident participation in the interview process.

Associate Lead Resident: In years where there aren't two PGY3s elected to be Leads, there will be a PGY2 Associate Lead Resident who will work with the PGY3 Lead Resident. The Associate Lead would be a second year resident who is peer elected in the second half of their PGY1. This person assists the lead resident with their duties, and attends meetings in the event the Lead is unavailable. The Associate Lead also attends an FM Lead Resident's conference at UW in the spring to help develop professional leadership skills and network with other resident leaders in the region.

**Refer to the Lead Resident and Associate Lead Resident Job Descriptions, and Lead Resident Timeline documents for more details about specific duties and election timeline.*

OB Lead Resident: The OB lead resident can be a second or third year who has a passion and interest in OB care, assists the OB faculty with their duties, helps to maintain the Epic Residency OB shared list and the OB patient spreadsheet in the clinic P drive in conjunction with the faculty OB lead, and attends the monthly Family Birth Center (FBC) workgroup when able.

Students

It is expected that all residents actively engage in teaching, leadership, and mentorship roles for students of all disciplines as appropriate in each clinical setting.

PNWU Medical Students: SRH is a core site for Pacific Northwest University of Health Sciences College of Osteopathic Medicine (PNWU) for training of 3rd and 4th year medical students. The FM residency clinic hosts 3rd year students for FM and Osteopathic Medicine rotations and 4th year students for audition rotations. There are always 1-2 medical students working in the Res clinic every month. There is usually a 3rd year medical student on the OB rotation as well as various inpatient services and subspecialty rotations.

**Refer to the annual PNWU Student Roster for 3rd and 4th year students and pictures.*

UW Medical Students: The FM residency clinic hosts 3rd and 4th year University of Washington (UW) students for FM rotations and audition rotations.

WSU Pharmacy Students: SRH is a regional core site for WSU 4th year pharmacy students. The FM residency clinic hosts pharmacy students part time when they are on Outpatient Clinic rotations.

Sub-internships/ Auditioning FM Medical Students: The FM residency hosts audition rotations for selected medical students during interview season. These rotations are usually designed to be 2 week rotations in our FM Residency clinic and with the inpatient FM team, depending on the timing of the rotation.

Section 3— FM Program

Mission

The mission of the SRH Family Medicine Residency is to improve health access and health status for rural, minority and underserved persons living in Washington by developing training programs for health professionals in our setting that serve those populations. Accordingly, our program involves a mutually beneficial educational relationship between regional hospitals, clinics, and local medical schools.

Overview

We train DO and MD residents with the hopes that many will stay and serve the Skagit community and surrounding area after graduation. We work with residents to individualize their training to meet their current needs and their future practice needs through elective rotations. We hope to promote the education of kind, caring, compassionate, patient centered, evidence based clinicians. We enjoy practicing alongside many of our graduates as colleagues, faculty, and mentors in our community.

Our goal is to produce professional, board certified family physicians capable of providing competent, independent, and professional health care service. In addition, we train physicians in the full breadth of primary care to serve rural and underserved communities, as well as promote independent learning skills to provide basic health care for all people.

**Please read the ACGME FM Program Requirements for a great description of what's being asked of us in each area or competency for FM training.*

Goals

Our goal is to produce professional, board certified family physicians capable of providing competent, independent, and professional health care service. In addition, we train physicians in the full breadth of primary care to serve rural and underserved communities, as well as promote independent learning skills to provide basic health care for all people.

Through the program the resident will complete an organized program of study and experience designed to prepare him/her to provide high quality medical care. The resident is exposed to the specific aspects of family medicine discipline, practical experience, reading materials and other resources.

Objectives

A. To provide learning opportunities for each resident to develop the ability to:
    1. Interpret in pathophysiological terms an accurate and complete initial and continuous database obtained through patient interviewing, physical examination, and appropriate laboratory evaluation.
    2. Accurately diagnose and completely manage the vast majority of primary care problems common to the office practice setting.
    3. Focus on the family as a unit, analyzing and appreciating the forces that affect health and illness.
    4. Work as a cooperative health-care team member relying on the skills of other health professionals.
    5. Appropriately utilize available community resources indicated for holistic care, including social,

nursing, legal, and religious services.

6. Understand, achieve, and utilize continuous relationships with patients toward the overall betterment of care.
7. Identify in epidemiologic terms the problems of the community as they affect the health of individual patients.
8. Operate and manage, effectively and efficiently, the office practice setting.
9. Select and utilize consultants from other disciplines at that point where diagnosis and management can be improved by such consultation.

B. To initiate and maintain programs that provide a stimulus for learning a model of care that has a beneficial impact on medical care and medical education within the community.

C. To enable the physician to modify his/her behavior to feel confident and at ease in dealing with people of all persuasions, convictions, and attitudes.

D. To develop a physician's awareness of his/her own personality traits, personal capabilities, limitations, and comfort in dealing with patients, colleagues, friends and family.

E. To create an environment within an educational model in which learning and emotional growth is a comfortable and natural process.

Rotation Goals & Objectives

On the first page you will always find some basics about who and where to meet, any specifics/ preferences that are known about this rotation, and a short list of high yield topics or procedures to make sure you focus on. Please help us keep these updated and make them more useful for every resident by giving feedback during or after your rotation to the faculty lead so they can update the document as needed. Some rotations have additional documents to help navigate the rotation (such as Inpatient IM/ Blue Team, OB, etc.)

If you are doing a new or unique elective/ selective rotation, you will need to create and document new rotation goals and objectives. Your advisor can help you with this. There are plenty of resources online that you will be able to find and modify into our format.

**Refer to each rotation G&O document in New Innovations.*

Section 4— Curriculum

Continuity of Care

Continuity of care is the primary mechanism of experiential learning in FM residency training. Each resident is expected to provide continuity care as the PCP (Primary Care Physician) of their own patient panel and will be assigned a set number of half day clinic sessions at the "FMP" ("*Family Medicine Practice*- this is ACGME's language) on a regular/ weekly basis during all rotational experiences throughout the residency. Generally, PGY1s will have at least 2 half day clinics per week, PGY2s will have 3, and PGY3s will have 4. These numbers will change on some rotations- for instance more on some outpatient rotations and less on some inpatient rotations.

All residents are required to see all types of patients presenting to the FMP and to provide/ learn to provide the full breadth of services including acute and chronic care, prenatal care and OB, office procedures, preventive care, risk management, education and counseling, and end of life care. Residents are required to work a minimum of 1000 hours in their continuity clinic, over a minimum of 40 weeks per year. (see ACGME requirements for more details.) Our program still requires a minimum of 1650 continuity patient visits in the continuity clinic prior to graduation.

Residents will provide continuity care in a variety of locations besides the residency clinic including following patients through hospital admissions, including obstetrical care overnight and on weekends, providing home visits, care at long term and skilled nursing facilities, hospice care, and even outreach care in the community. (There is a supplemental guide for community outreach for more details.) Residents will manage and help patients navigate the transitions of care associated with each phase. As the PCP, residents are expected to coordinate their patients' care with all specialists, including communication and advocacy, and leading/ managing a patient care team. Residents will be responsible for taking phone calls from patients overnight and on weekends on outpatient rotations throughout the year, per the on-call schedule made and maintained by the lead residents. Core faculty will provide oversight and backup for residents at all times.

Rotations

Required (core) rotations will be scheduled automatically by the residency coordinator. Rotation requests for electives should be submitted by March for the following academic year. We will not generally change rotations once the academic year is set due to the impact on other residents and patients- but we understand sometimes issues arise for both attendings and residents, and although we cannot guarantee each request we will do our best to accommodate when there are urgent needs. Elective rotations should be considered as a part of each resident's Individualized Learning Plan (ILP) and discussed with/ approved by their advisor and the program director to be in line with their long term practice goals.

Our goal is to keep all rotations within SRH if available. All inpatient rotations will only be scheduled at SVH, as residents are not allowed to rotate at CVH currently. Outpatient rotations will be at a variety of SRH sites with SVH/ Mount Vernon area being the focus, and residents will need to travel to other SRH sites as needed for attending availability.

If not available within SRH, a rotation may be possible at an outside site. This will take much longer to arrange, since new contracts and affiliation agreements may be necessary, and we will need at least 6 months' notice for coordination. Outside electives may be allowed in the PGY2-3 years, no more than one away rotation per year. Within our regional residency network of FM programs, we may have some options available for possible international rotations, and request a year in advance to coordinate these. This is associated with a cost that would be covered by the resident.

Our year is divided into 13 four-week blocks. PGY1, PGY2 and PGY3 residents begin each block on a Monday and end their blocks on Sunday. Inpatient rotations are typically requiring work on one weekend day per week, and outpatient rotations may require work on one weekend day per week as well. Work hours per day vary with each rotation. Each resident is assigned to a specific service or rotation for each block. The resident is responsible to the attending physicians and any senior residents or fellows on that service or rotation, and for adhering to all policies and procedures of the rotation site. It is the resident's responsibility to confirm with the supervisor when the workday begins and to be ready for work by that time each day. Information can be found on the first page of each rotation goals and objectives document in New Innovations, and should be verified with the attending.

Required Rotations listed below may be shifted from one year to another with program director approval, or as necessary by the program, but must be completed by the end of residency.

PGY1 REQUIRED ROTATIONS	PGY2 REQUIRED ROTATIONS	PGY3 REQUIRED ROTATIONS
Inpatient Adult Medicine – 12 w	*Inpatient Adult Medicine – 8 w*	*Family Medicine Practice – 4 w*
Inpatient Obstetrics – 8 w	*Family Medicine Practice – 4 w*	*Emergency Medicine – 4 w*
Emergency Medicine – 4 w	*Geriatrics – 4 w*	*Pediatric Emergency Med (SCH) – 4 w*

Family Medicine Practice – 4 w
Geriatrics - 4 w
OB/Gyn Outpatient - 4 w
Pediatrics Inpatient – 4 w
Pediatric Outpatient – 4 w
Addiction Medicine - 2 w
Cardiology Outpatient - 2 w
Orthopedics - 2 w
Surgery – 2 w

OB/Gyn Outpatient – 4 w
Geriatrics – 4 w
Pain (Interventional) – 4 w
Dermatology – 2 w
Endocrinology – 2 w
Infectious Diseases – 2 w
OMM – 2 w
Pediatrics Inpatient SCH – 2 w
Psychiatry Inpatient – 2 w
Sports Medicine – 2 w
Electives – 10 w

Inpatient Adult Medicine – 4 w
Pediatric Outpatient – 4 w
ENT – 2 w
Podiatry – 2 w
Rheumatology – 2 w
Wound Care – 2 w
Electives – 24 w

Elective Rotation Options

Addiction Medicine
Anesthesiology
Dermatology
Emergency Medicine
Endocrinology
ENT
Gastroenterology
General Surgery
Geriatrics
Hem/Onc
ICU
ID
Inpatient Psychiatry
Inpatient IM (blue or yellow teams)
Nephrology
Neurology
OB Inpatient
Ophthalmology
Orthopedics
OMM (outpatient and/or inpatient)
Pain (Interventional)
Palliative Care
Peds Outpatient or Inpatient
Plastic Surgery
POCUS
Podiatry
Outpatient OB/Gyn
Rheumatology
Rural FM
Residency Clinic
Wound Care
Sleep Medicine
Sports Medicine
Urgent Care
Wound Care

Osteopathic Recognition (OR)

All FM residents will be taught skills in OMT (osteopathic manipulative treatment) and about the osteopathic philosophy as it applies to patient care. We have a very strong osteopathic faculty to teach and model osteopathic care in a variety of patient care settings. Osteopathic skills workshops and journal clubs will be integrated into our didactics curriculum for all residents. For residents interested in advanced training, there are inpatient and outpatient OMM elective rotations available as well as specialty conferences for many different types of osteopathic treatment. There are also local and regional workshops available for MDs who are seeking extra knowledge about osteopathic treatment.

All DO residents will be automatically enrolled in the training for Osteopathic Recognition. MD residents can apply for it if they choose, per our program's policy on OR.

**Refer to the Osteopathic Toolkit in the FMRN Network Digital Resource Library (NDRL) for more information and resources. Link is in New Innovations under Reference Materials.*

Didactics and Workshops

In addition to the experiential learning of continuity patient care and patient care on rotations, residents' knowledge and skills will be augmented with a schedule of didactic activities. There will be a combination of FM and specialty faculty and resident-led presentations. Residents are expected to attend, and the time is protected from clinical responsibilities. All attendings are aware that this is protected time, and it's OK to remind them. (Residents can be excused occasionally for patient care needs, and our program requirement is at least 75% attendance to allow for this.)

Presentations usually occur in the GME didactics rooms. The schedule is located in New Innovations. Attendance must be recorded in New Innovations with the QR code provided. Specific topics and details for the week can also be found on the white board in the GME hall by the coordinators' office. Didactics presentations are for residents and medical students, and some will include IM residents.

Morning Report is required for all residents on inpatient FM and IM teams and ICU rotations, and per your rotation attending for some inpatient medicine specialties.

Noon weekday didactics and monthly Skills Workshops are required for all residents except those on Night Float & at Seattle Children's. Senior residents on inpatient teams should protect time for their interns so they are able to attend didactics and skills workshops, even if it means the seniors need to excuse themselves. Didactics may be attended virtually via the provided Zoom links in New Innovations, when appropriate/ available.

**Zoom links for FM and IM didactics are on the New Innovations homepage.*

Weekly Schedule for Didactics

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	7-7:30 Morning Report	7-:730 Morning Report	7-7:30 Morning Report	7-7:30 Morning Report	7-7:30 Morning Report
PM	12:15-1:15 Didactics	12:15-1:15 Didactics	12:15-1:15 Didactics	1215-1:15 Didactics 1:15-5:30 Procedure Skills Workshops- 2nd week of every block	12:15-1:15 Didactics

General Outline for Didactics

Block	Monday	Tuesday	Wednesday	Thursday	Friday
Wk 1	FM Wellbeing or Primary Care Psychiatry	FM QI/ Epic Dashboard/ Panel Management	IM/ FM Combined Palliative/ Hospice	FM OB or Outpatient Peds OB Simulation for OB residents	FM resident-only Meeting/ Program Meeting/ Quarterly FM/ IM resident joint meeting
Wk 2	FM Journal Club (FPIN & OR) - FMP resident-led	IM/ FM Combined Specialty/ Quarterly DIO meeting	IM/ FM Combined MMI Presentation	FM Skills Workshop/ Quarterly Clinic All-Staff meeting IM/ FM Combined Mock Code for inpatient residents	IM/ FM Combined High Value Care (ACP) or Healthcare Equity Topic or Quarterly DIO Meeting

Wk 3	FM Outpatient Med/ OMT	IM/ FM Combined Specialty	FM Outpatient Med	FM Guidelines- FMP resident-led/ Quarterly SRH All-Primary Care meeting	IM/ FM Combined Specialty
Wk 4	FM Board Review- Outpt- resident-led	Pediatrics Inpatient/ Quarterly Peds Simulation- Peds hosp-led	IM/ FM Combined Specialty OB Simulation for OB residents	FM Outpatient Med/ OMT IM/ FM Combined Mock Code for inpatient residents	Finishing Friday - coordinator-led

**Refer to the supplemental document FM DIdactics How-to for details about resident-led presentations*

Scholarly Activity

All residents are required to complete at least one scholarly activity of writing a short article called a Family Physicians' Inquiry Network (FPIN) "Help Desk Answer" to be published in the peer-reviewed Journal of Evidence-Based Medicine. This is generally done as a group in PGY1, but an FPIN "GEM" (Good Evidence Matters) article will also suffice to ensure that all residents know how to search, interpret, and apply medical research to articles. Residents will present their article on SRH Scholarship Day in Spring of PGY2-3 and to their FM peers during didactics after acceptance for publication.

Additionally, there is a QI project required with a final poster presentation. This will follow a PDSA cycle and often is tied to a clinic healthcare metric or program advancement to meet ACGME milestones. Our goal is for you to have a project, proposal, and timeline completed by the end of PGY1, with study/actions in PGY2 with presentation and handoff by PGY3. Residents will present these on Scholarship Day in Spring of PGY2-3 and to FM peers during didactics. Publication/ regional/ national presentation is encouraged, but not required. If you present at a regional or national conference, we will prioritize giving time to attend, per program director discretion. Potential poster presentation locations are mainly in the spring at UW at WA Primary Care Research Network (WPRN), ACOFP or AAFP, WOMA or WAFP annual conferences.

All residents are required to prepare and present in didactics for Journal Club using the FPIN PURLS Journal Club format and an accompanying osteopathic article (this can be OMT, anatomy, or a related biopsychosocial topic). Other possible scholarly activity includes: presentation at regional, state, or national meeting, grand rounds, publications of articles, book chapters, abstracts, or case reports in peer reviewed journals, publication of peer-reviewed performance improvement or education research, obtaining peer-reviewed funding, presentation of peer-reviewed abstracts at regional, state, or national specialty meeting, or leadership in a regional, state, or national osteopathic-related organization.

OR residents have an additional requirement for an osteopathic scholarly activity and this can be incorporated into another QI project or satisfied in other ways. OR residents are encouraged to present at the monthly Family Medicine Residency Network (FMRN) Osteopathic Grand Rounds, and are required to teach their favorite techniques and to assist with didactics (learning, teaching, practicing or table training throughout all years).

SRH is a member of the Washington Primary Care Research Network (WPRN), and the residency clinics participate in various clinical research projects. SRH encourages resident participation in interdepartmental and interprofessional scholarly projects when available.

**Refer to New Innovations for timeline for scholarly projects and proposal for QI projects for the SRH Institutional Review Board*

Independent Study

Independent study is a vitally important and often poorly emphasized area of resident training and preparation. Residents are expected to maintain a program of independent self-study sufficient to acquire the knowledge and skills necessary for achieving success in their clinical experiences and on their required examinations. Here are some suggestions:

Relevant Reading: At least 20 minutes a night on a topic relevant to a case seen that day, or in preparation for the next. (Up to Date, Dynamed, Clinical Inquiries)

Rotation Specific Review: "NEJM Resident Rotation" has sections relevant to each core rotation in Family Medicine.

Board Review/ Practice Questions: Integrate True Learn, UWorld, or Amboss questions into weekly studying and longitudinal planning. It is a program requirement to complete a minimum of 500 practice questions (1500- 2000 are recommended) from True Learn for DOs and UWorld or Amboss for MDs by the end of PGY1 prior to Step 3 exam. Minimum 500 True Learn practice questions required prior to board exams, ABFM has 1000 practice questions available free of charge.

Family Medicine References:
American Family Physician: AFP Journal: Pertinent board relevant articles (there is also a podcast)
Family Physicians' Inquiry Network (FPIN): Help Desk Answers, Evidence Based Medicine
Essential Evidence Plus: Daily POEMS (emailed or podcast)
Smart Briefs: Family Medicine, Nutrition
NEJM: Journal Watch
American Academy of Family Physicians (AAFP): FM Residency Curriculum Guidelines- extensive resources at the end of each

Osteopathic References:
Journal of Osteopathic Medicine (formerly Journal of the American Osteopathic Association- JAOA)
American Academy of Osteopathy (AAO) Journal
Osteopathic Family Practice (OFP) Journal
International Journal of Osteopathic Medicine (IJOM)
5 minute OMM Consult; Channell & Mason (2009)

**Refer to the Osteopathic Toolkit in the FMRN Network Digital Resource Library (NDRL) for more resources. Link found in New Innovations under Reference Materials.*

Leadership and Teaching

All residents are mentors and teachers to junior residents, medical students, pharmacy students, and other members of the interdisciplinary team. Duties should be clearly delineated by the senior resident with the attending at the beginning of the rotation, and shared with the team.

Beyond the specific duties of a rotation, each resident is expected to assist peers and juniors with tasks, assignments, and duties related to residency, clinic, hospital, being on call, on rotation, wellbeing, career goals, etc. Listen and offer tips, tricks, resources, and wisdom as you can. We all come from diverse backgrounds and have learned a lot on our journeys in medicine (and life) thus far, and have a lot to share with one another.

Teaching and leadership skills are expected in the medical community, and are integrated into most ACGME milestones.

SRH GME and Hospital Committees

Residents are encouraged to be members of committees and to participate in leadership roles within our organization as well as our profession locally, regionally, and nationally. If interested, the GME and SRH committees meet monthly or quarterly. Talk to your advisor and Dora about what interests you, so you can think about joining, and getting it scheduled so you can attend.

GME: GME Committee (GMEC)- Wellness Subcommittee, Healthcare Equity Subcommittee, Clinical Learning Environment Review (CLER) Subcommittees, Institutional Resident Advisory Committee, and new this year a committee on AI

SRH: Pharmaceuticals & Therapeutics (P&T), Antimicrobial Stewardship, Ethics, Healthcare Equity, Employee Engagement, Patient Engagement, Institutional Review Board (IRB), Professional Enhancement Committee (formerly called "Peer Review"), Family Birth Center (FBC) Workgroup, Family Planning Committee, and new this year a Community Health Committee

Section 5— Supervision and Evaluation

ACGME Family Medicine and Osteopathic Recognition Core Competencies

Professionalism, Patient Care and Procedural Skills, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Systems-based Practice.
As a program with Osteopathic Recognition, osteopathic principles and practices are woven throughout each competency and area of our program.

**Refer to the ACGME Program Requirements for details*

FM and OR Milestones

From ACGME IV.A.: The trajectory to autonomous practice is documented by Milestones evaluation. The Milestones detail the progress of a resident in attaining skill in each competency domain. They are developed by each specialty group and allow evaluation based on observable behaviors. Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

Milestones were designed for programs to use at the beginning of residency and then in at least semi-annual review of each resident's performance and must be reported to the ACGME semi-annually. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies, organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation.

Milestones are arranged into levels. Selection implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels. A general interpretation of the levels is below:

1: Expected of a resident who has had some education in family medicine

2: Advancing and demonstrating additional milestones
3: Continues to advance and demonstrate additional milestones; consistently demonstrates the majority of milestones targeted for residency
4: Substantially demonstrates the milestones targeted for residency. *this is the graduation target
5: Advanced beyond performance targets set for residency and demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years- it is expected that only a few exceptional residents will reach this level

**Refer to the ACGME Milestones documents and Supplemental Guides (FM Revision 2019, and OR 2021) for full details:*
familymedicinemilestones.pdf (acgme.org)
osteopathicrecognitionmilestones.pdf (acgme.org)

ABFM Competency Based Medical Education

The ABFM now requires PD attestation for all residency graduates of Core Outcomes of Family Medicine, in order to become board certified. They are working closely with the ACGME FM Review Committee to reinforce the competency-based education. There is also a required procedure list which we have incorporated into our curriculum.

**Refer to the ABFM website or their JABFM article for full details*

Supervision

Board-certified physicians in each specialty will supervise all patient care. Schedules are structured to provide residents with continuous supervision and consultation available. Nurse Practitioners, Physician Assistants, or other similar providers may supervise residents as long as there is also a board-certified physician involved in the oversight.

From the SRH GME policy: Resident education is progressively graduated in both experience and responsibility with primary attention to the benefit, and safety of the patient. Development of mature clinical judgment requires that each resident be involved in the decision-making process. The conditional independence of the resident should be determined by each program and individualized to be commensurate with the clinical circumstances and ability of the resident.

In such an environment, each physician participating in the clinical training environment will have specific and defined roles and responsibilities:

Residents

1. Are supervised by an attending physician or other appropriate provider;
2. Are responsible for being aware of their limitations, roles, and responsibilities within the course of patient clinical care;
3. Must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence;
4. Are supervised in a manner consistent with national standards of supervision as defined by the ACGME;
5. Are provided progressive authority and responsibility, conditional independence, and, when appropriate, a supervisory role in patient care as assigned by the program director and faculty members;
6. Are expected to communicate effectively with attending physicians and other members of the health care team;
7. Are required to inform patients of their respective role in each patient's care.

Communication between residents and the attending physician will occur at the time patient care decisions are being made. Prior to clinical care decisions, the attending physician will facilitate communication regarding care decisions. Examples include, but are not limited to, the following:

1. Admission and discharge of a patient;
2. Decision-making applied to high-risk or complex procedures and/or interventions, to include surgeries, use of moderate sedation, and high risk or complex diagnostic procedures;
3. An important change in status occurs and/or when a patient is transferred from one service to another and/or from one level of service to another (e.g. admission of a patient from the clinic, transfer of a patient to intensive care unit, etc.)
4. When a patient's condition is unexpectedly deteriorating, or when a patient is not improving clinically in an expected fashion or time course; and
5. When disclosure of a significant adverse event is necessary.

Clinical consultation ranges from verbal advice to interdisciplinary concurrent care. The documentation will reflect the complexity of the clinical question and degree of consultant involvement.

In an emergency situation to preserve life or prevent serious impairment to health, residents shall be permitted to implement life support services. Notification must be made to the supervising physicians as soon as possible. The responsibilities of the attending physician to the patient and to the residents are not changed by these circumstances.

PGY1 Supervision:
All PGY1s are directly supervised until it is determined that they can advance to indirect supervision. This is determined by direct observation from an attending or senior resident, or an OSCE.

In the FM Residency Clinic- all PGY1s must discuss every patient with a preceptor while the patient is in the office, and the preceptor must see each patient in person at least until 6 months of residency has been completed satisfactorily, and the PGY1 is approved by the CCC to advance. Any virtual or telephone encounters performed in the first 6 months of training must have a preceptor directly participating in the call, per CMS billing and supervision rules.

All procedures including OMT will be directly supervised until the resident is approved to advance. We have an OMT OSCE to evaluate all new DO PGY1s. Basic Skills Qualification (BSQ's) with step-by-step guidelines to measure and record residents' progress to independence. BSQs help track competency of skills, and even when a resident is deemed "independent", a preceptor must be present for billing purposes. (Direct supervision may be required for billing purposes, even after a resident has achieved "independence", since all billing is in the name of the supervising physician.)

**Refer to the GME/ FM policy and the CMS Guidelines for Teaching Physicians, Interns & Residents for full details*

Handoff Process:
When possible residents and faculty will identify a quiet area to give report that is conducive to transferring information with few interruptions. Off-going providers will have at hand any supporting documentation or tools used to convey information and immediate access to the patient's record.

All communication and transfers of information will be provided in a manner consistent with protecting patient confidentiality. Residents will use the modified I-PASS format as well as the handoff tab in EPIC, and training will be provided.

Providers will afford each other the opportunity to ask or answer questions and read or repeat back information as needed. If the contact is not made directly (face-to-face or by telephone), the provider must provide documentation of name and contact information (extension, cell number, or email address, etc.) to provide

opportunity for follow up calls or inquiries. The patient will be informed of any transfer of care or responsibility, when possible.

**Refer to the GME Supervision of Residents Policy for full details*

Examinations

In-training exams: Every year the ACOFP in-service examination (ISE) is administered in October (2nd week). All DO residents are required to complete it. MD residents interested in Osteopathic Recognition may elect to take the ACOFP Cortex examination, which covers OMM/OMT knowledge, but they are not required to do so.

The AAFP in-training examination (ITE) is administered in October (4th week) and all MD residents are required to complete it. DO residents may elect to take this exam, in addition to the ACOFP exam. We recommend it for those DOs potentially interested in future fellowships, academic work, or who want to keep all options open.

COMLEX 3 and USMLE Step 3: SRH requires that all PGY1s schedule their Step 3 by the end of PGY1. All residents should pass Step 3 by January of PGY2 to ensure they get their PGY3 contract at the usual time.

Residents must pass Step 3 prior to beginning the PGY3 year per ACGME requirements. Failure to do so means a contract for PGY3 will not be offered and the resident may be dismissed from the program. (Contracts are prepared in January prior to the next academic year.)

FM Board Certification Exams: Residents are required to take ABFM or AOBFP exams in the winter/ spring of their PGY3 year.

Practice Exams: Both ACOFP and ABFM prior years' exams are available and can be used for practice.

Evaluation and Promotion

Resident Self-Evaluation:
Residents will evaluate themselves and create an Individual Learning Plan (ILP) to help them direct their learning during the program, keeping their own goals, as well as program requirements in mind. ILPs will be completed at the start of residency and updated quarterly by each resident reviewing their own data and goals, and faculty advisors will review the ILPs during quarterly evaluations and will assist residents as needed and may suggest information that should be added.

Evaluation of Rotations and Faculty:
Residents are required to evaluate their rotations/ experiences and faculty, as well as be evaluated by faculty at least every 4 weeks at the end of each rotation. We suggest that residents and faculty give verbal feedback every day or every half day, since timely and specific feedback is the most useful. All written evaluation will be in New Innovations. "Field Notes" are a way to give brief feedback in the moment. End of rotation evaluations will be sent to all parties in the 4th week of the rotation. Resident comments go directly to the advisor and program director, and are given anonymously to the rotation attendings at the end of each academic year at a minimum. If there is a substantial issue recorded in a resident evaluation of an attending or a rotation, then advisors and the program director will address it in a timely manner. 360 degree evaluation is integrated through every part of the training: residents and faculty will be asked to evaluate each other and perform self-evaluation, and feedback will be obtained from patients and staff.

Evaluation of Residents:

Residents are assigned a class advisor who will perform quarterly evaluations. These quarterly evaluations will include direct observation evaluation/ patient care shadowing, review of all written evaluations, logs, BSQs, and data in NI, review of Milestones progress, and review of each resident's ILP (Individualized Learning Plan) and their progress towards their goals. Advisors will help residents learn to set "smart" goals as needed, and may suggest items that should be included in the ILP.

Residents are reviewed by the Clinical Competency Committee (CCC- made up of core faculty) quarterly, or at least twice a year. The CCC determines each residents' progression along the Milestones and toward independent practice. The program director and coordinator must report all residents' Milestones to ACGME twice a year.

For procedures BSQs (Basic Skills Qualifications) will be used for standardization of evaluation of procedures. Residents should be prepared for procedures ahead of time (review BSQ, video, discuss with preceptor), and BSQs should be reviewed during debrief with the preceptor who is supervising the resident directly after the procedure until they have completed two for each required and recommended procedure. Once a resident has achieved competency in that area they can be signed off on that particular procedure on the BSQ sign off sheet to be able to do the procedure with direct supervision, but more independently. (Direct supervision is required in the outpatient setting for billing purposes.) Procedures should always be logged in New Innovations to keep a record of total number of procedures performed for future credentialing.

If there are concerns about a residents' performance, there will be a Performance Improvement Plan (PIP) developed for the resident with/ by the faculty to help guide the resident to address the concerns promptly. Concerns may be in any area of the competencies for FM, such as medical knowledge, professionalism or communication. An area that will initiate a PIP is underperformance on the annual in-training/ in-service exams, or failure of Step 3, due to concerns about medical knowledge and the exams predictive value for ability to pass the FM boards. Any PIP that is not resolved by the resident can result in continuation of the PIP or even escalation to Probation. (Probation will involve our DIO and must be reported to future employers as a permanent part of that resident's file.)

The Program Evaluation Committee (PEC) is made of core faculty, program coordinator, and lead residents and will evaluate the program as a whole. Reports will be made to the residents and faculty, and at least once a year, will prepare an Annual Program Evaluation (APE) with an Action Plan which will be reviewed and updated regularly. We consider the APE a living document to be reviewed and worked on throughout the year as we strive for continuous improvement.

**Refer to the GME Policies for full details: Evaluation, Promotion of Residents, Academic Improvement and Corrective Action*

Section 6— Program Logistics

Call

All residents share in taking after-hours phone calls for FM Residency Clinic patients while on outpatient rotations. This includes nights, weekends, and holidays. The on call resident may get called during didactics occasionally when there isn't an RN to cover in the clinic for lunchtime. The core faculty will cover calls during skills workshops, as needed for clinic meetings, and also help cover lunchtime needs.

PGY1s will start taking call in October at the earliest, or after 3 months of residency experience. The lead resident makes the schedule to ensure coverage and fair distribution. There is a core faculty backup on call for any questions you have. The schedule is in New Innovations and in AMION (found on the intranet under the Provider tab). Changes to the schedule need to be communicated asap with the lead residents and the coordinator in order to update AMION and notify the answering service.

All residents must have 1 day off in 7 (averaged over 4 weeks) without any assignments including call from home. Core faculty will take call if/when there aren't enough residents on outpatient rotations to cover, and during resident retreats.

Since OB continuity call for your own patients can't be specifically scheduled, we rely on residents to communicate with a core FMOB faculty or PD if they haven't had enough time off in a given block.

Communication

All residents receive an SRH email account, and this will be the primary means of communication for program information. Residents are required to check their email daily and respond appropriately in a timely manner. Computers with internet access are available in the library, on all floors of the hospital, and in the residency clinic. Email will be automatically deleted from the server after 180 days. (see SRH policy)

Other communication to residents could be via written memorandum, telephone, text, AMS paging, and Viber. No patient-identifying information will be transmitted via text or email due to HIPPA. Epic has a secure chat for patient care communication which is also available in a smart phone app (Haiku). Residents are currently expected to be available via AMS paging during the work day and when on call for immediate responses.

All residents are required to check their Epic In Basket daily at minimum, and respond appropriately to all staff and patient needs to ensure timely communication, patient safety, and quality of care. When on vacation, residents will have another resident on their clinic team to cover their in basket and update EPIC and email with an out of office message naming the person who's covering. This will also be communicated to the lead residents for sharing with all staff. (see Epic communication below in the Clinic section)

Educational Stipend

Residents receive an annual stipend for educational materials which is outlined in the resident contract. This stipend must be used for educational materials and cannot be used for equipment. Residents typically use this to pay for Step/ Level 3 in PGY1, a review course, question bank, or practice tests in PGY2, and board examination fees in PGY3.

Receipts will be required for any reimbursement, and we recommend paying for everything with a credit card so all payments can be easily documented and tracked.

**Please see residency coordinator for reimbursement forms to access funds from your stipend or to ask for use of the GME Credit Card to prepay for something.*

EHR Medical Record Completion

Residents are expected to complete medical records at the time of service. Inpatient notes must be completed right after rounding and before leaving for afternoon clinics. Clinic notes should be completed before leaving for the day. In some instances, clinic notes can be completed that evening from home- but caution should be used since those hours would still be logged as work hours- and when working from home it is sometimes complicated due to multitasking, interruptions, home environment distractions, etc. (Per SRH Policy- all notes must be completed and signed within 24 hrs. And then preceptors must sign/ attest within 48 hrs.)

Meal Stipend

Residents receive a set meal stipend for their own personal use only during work hours at SRH and SCH. They are not to provide food for medical students, friends, or family members. Some limited items are also available in the GME break room for those working nights or weekend times when the cafeteria is closed.

Moonlighting

Any professional clinical activity ("moonlighting") performed outside of an official residency program will only be conducted with the permission of the DIO and Program Director.

PGY1 trainees are prohibited from moonlighting, per ACGME. Residents may only be permitted to moonlight provided that such employment does not interfere with their educational program and it must not represent a conflict of interest. The resident must be in good standing within the residency program, and all residency requirements, institutional requirements, logs, evaluations, and medical records must be up-to-date.

An application by the resident must be approved or disapproved by the DIO and Program Director and be filed in the resident's file. Failure to report and receive approval by the program may be grounds for dismissal. If moonlighting is permitted, hours shall be inclusive of the 80 hour per week maximum work limit and must be reported to the Program Director and monitored by the GMEC. All residents engaged in moonlighting must have a separate, permanent medical license, and must have separate malpractice insurance coverage for their employment duties.

**Refer to the GME Resident Moonlighting Policy for full policy details and application for moonlighting*

New Innovations

New innovations is your daily hub for your assignment schedule, where you log your daily work hours, procedures, didactic presentations you've attended and given, as well as your scholarly activity. It is where you will complete evaluations on each rotation and attending, as well as find all evaluations about your performance and progress. Your Individual Learning Plans, quarterly evaluations and milestones reports are saved here as well as all certifications. You'll find Advancement Checklists for each PGY to help guide your progress through the program, as well as links to many resources.

It is required that you log your duty hours and log all procedures performed. It is recommended that you log all procedures right after you perform them. Documentation must include the procedure name (be as specific as possible- and there is a comment box), date performed, role in the procedure (performed, assisted, etc.), supervising physician, and 2 separate patient identifiers like MRN and birthdate (no patient names)- so you could find the record again if needed. The residency coordinator can add procedures or supervising physicians to the list of choices, if the item needed is missing.

The purpose of logging all procedures is to document training and competence in procedural skills- and also to create a list to provide to future employers for any procedures you seek privileges for. This includes hospital medical staff offices for inpatient procedures and outpatient office credentialing, long term care facilities, etc. You will be required to show proof of competence in any procedure you want to do after graduation. If you don't log the procedures, there will be no record to share with your future employer.

Paid Time Off

Each resident will have 20 days of paid time off (PTO) per year, and 7 sick days. Residents must have all time-off requests approved by the Program Director and Coordinator at least 3 months in advance, and before the start of the new academic year. PTO includes all approved time off- vacation, personal leave, elective educational conferences, and any other requested time off work. Extensive medical or family leave will be handled per GME policy with attention to rotation requirements and milestones achieved.

No PTO will be granted on most inpatient rotations or the first block of intern year. No more than 1 week will be granted away in any 4 week rotation, or 2 days in any 2 week rotation, in order to preserve the integrity of

the educational experience. If 2 weeks in a row is requested, it can span 2 eligible rotations or will need to be taken during an elective rotation.

Residents are always encouraged to take care of their own physical and mental health. If time is needed for medical appointments, please notify the program coordinator, who can help with scheduling timing as needed. We understand some issues are urgent; we encourage residents to schedule non-urgent appointments when they are not scheduled in their continuity clinic or on an inpatient team to minimize patient care disruptions.

**Refer to the GME Paid Time Off Utilization Policy and the Effects of Leave of Absence Policy for more details*

Parking

Residents/ employees are not to park in patient parking lots. There are maps that show designated SRH staff and physician parking lots, and parking is found on side streets around campus as well. SRH security is tracking this and will ticket or tow your car if parked inappropriately. Please be courteous to our patients.

Note that security is available to walk you out to your car if requested due to darkness, safety concern, etc.

Sick/ Emergency/ Who to notify?

If you're sick, we want you to stay home and get well. If you have an emergency- let us know! Communication helps everyone navigate things more successfully. Who you have to call depends on your work assignment(s) for the day.

Always **text** your residency coordinator and program director (we recommend both in the same text please!), as well as your rotation attending for that day, and senior resident as applicable. Please make sure you receive confirmation that your message has been received. You'll need to notify them each day you'll be out. Emails are not timely enough for this sort of notification!

Once you are back to work, then we'll figure out how to account for your time off. (Can you make up the time, do you have PTO to use, will it extend your training year, etc?)

Hours

Residents must adhere to the policies regarding work hours. The training schedules will be closely monitored to assure compliance with ACGME work hour requirements.

Maximum Hours of Clinical and Educational Work per Week: Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Clinical Work and Education: Residents must be scheduled for a minimum of 1 day (24 hours) in 7 free of clinical work and required education- averaged over 4 weeks. At-home call cannot be assigned on these free days.

Maximum Clinical Work and Education Period Length: Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. Up to 4 hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions: In rare circumstances, after handing off all other responsibilities, a resident may elect to remain or return to the clinical site in the following circumstances: To

continue to provide care to an OB continuity patient, a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or to attend unique educational events. These additional hours of care or education will be counted toward the 80-hour weekly limit.

> Sometimes work hour questions arise when you've done a continuity delivery at night or over a weekend. You should have 8 hrs off before your next shift, and if you work more than 24 hrs- you need 14 hrs off. We recommend always discussing it with the PD or one of your FMOB core faculty to explain the situation, and determine the best way to handle it.

Duty Hour Violations: If a duty hour violation occurs, please specify the reason for the violation when logging your duty hours in New Innovations. Notify your attending of the occurrence and adjust your schedule as needed. Contact the program coordinator, your advisor, or the program director if you have questions about what your options are to avoid duty hour violations in the future.

**Refer to the ACGME resident work hours requirements for full details*

Section 7 – Important Links

Residency Training Requirements

You are responsible for understanding the requirements of your three-year residency program. You can find documents for "(FM) Program Requirements and FAQs", as well as "Osteopathic Recognition".
Program Requirements and FAQs and Applications (acgme.org)
Osteopathic Recognition (acgme.org)

COMLEX Step 3 and USMLE Part 3 Requirements

Residents must have successfully passed COMLEX 3 (National Board of Osteopathic Medical Examiners-NBOME) or USMLE 3 (United States Medical Licensing Examinations) before receiving a contract for PGY3 or beginning the third year of training, per ACGME and SRH policy. Failure to pass by 120 d prior to the start of the PGY3 year will result in delay or non-renewal of the resident's contract.
www.nbome.org www.usmle.org

**Refer to the GME policy Passage of Medical Licensing Examination*

FM Board Certification Requirements

Information on FM Board Exams and certification requirements can be found at the American Board of Family Medicine (ABFM) and American Osteopathic Board of Family Physicians (AOBFP):
www.theabfm.org www.aobfp.org/home.html

Memberships

All residents shall become members of the national FM organizations American Academy of Family Physicians (AAFP); and American College of Osteopathic Family Physicians (ACOFP) and American Osteopathic Association (AOA) for osteopathic residents. Membership in the American College of Obstetricians and Gynecologists is recommended for all interested in OB.
www.aafp.org www.acofp.org osteopathic.org www.acog.org

ASCCP Colposcopy membership & training/certification if you are interested:

Membership $15 for residents https://www.asccp.org/member-benefits
Training Courses https://www.asccp.org/courses

Residents shall also become members of the state societies Washington Academy of Family Physicians (WAFP); and Washington Osteopathic Medical Association (WOMA) for osteopathic residents.
www.wafp.net www.woma.org

In addition, our residents all have the benefit of being part of the UW/ WWAMI FM Residency Network and this provides collaboration with other FM programs in our state as well as our PNW 5 state region, and gives each person a UW Net ID.
WWAMI Network Annual Events Calendar – WWAMI Network (uw.edu)

Skills Certifications Required

BLS (Basic Life Support)
ACLS (Advanced Cardiac Life Support)
PALS (Pediatric Advanced Life Support)
NRP (Neonatal Resuscitation Program) and
ALSO (Advanced Life Support in Obstetrics)

Washington State Medical Licensure

Resident trainees obtain a *Limited License* from the State of Washington.

Residents interested in Moonlighting can apply for a *Full License* in Washington after passing COMLEX 3 or USMLE 3 *and* successfully completing your first year of residency training. After residency, you will need to apply for a *Full License* to practice independently.

MDs are found under "P" for "Physician" on the WA Department of Health Website list of Professionals- and are handled by the "Washington Medial Commission":
www.doh.wa.gov https://wmc.wa.gov

DOs are found under "O" for "Osteopathic Physician" on the WA Department of Health Website list of Professionals- and are handled by the "Board of Osteopathic Medicine and Surgery".
www.doh.wa.gov

Section 9- GME Resident Policy and Procedure Manual

Please note that residents as learners fall under ACGME program requirements. This means that we must follow GME policies, which have been developed specifically for residents- and there may be differences from existing SRH (non-GME) policies. If there isn't a specific GME policy or guideline, then residents are expected to follow the SRH policies and procedures.

For example, there is a GME policy for Paid Time Off and residents are subject to ACGME requirements, rather than SRH/ HR department policies that apply to other employees.

**Refer to the SRH GME Resident Policy and Procedure Manual in New Innovations.*
**Ask a GME coordinator, administrator or program director if you have questions or need anything!*

Section 10— FM Residency Clinic

Clinic Hours

Current clinic hours are Monday-Friday from 7:30am-5:30pm. Patient appointments are currently 8am-5pm. No patient appointments are scheduled for residents from 12:00-1:30 to allow residents to attend required didactics from 12:15-1:15 and staff to have lunch from 12-1. Clinic hours are subject to change to include evening or weekend hours.

If you have a patient here past 5:30, you will need to open the front door with a key for patients to exit, or escort them out the side or back door. The key for the main door is at the front desk. Please locate this when you start. Please be respectful of staff at the end of the day. If you are running behind, the MA will check in with you to see if you need them to stay. If there is nothing left for them to do, they will leave. Same with the receptionist.

Staffing and Roles

#	Title	Role
5	Medical Assistant-Certified (MA-C) Full Time/ shifts vary (plus a per diem)	Work 1:1 with a provider. Rooming, med/vaccine administration, procedure set-up/clean-up, ECGs, process paperwork/faxes, work in basket, all patient care w/in scope of practice
	Medical Assistant-Registered (MA-R) Full Time/ shifts vary	Float pool is used for coverage and MA-Rs have been trained at SRH in various departments. They aren't able to do the full breadth of things the MA-Cs can.
1.8	RN Triage Nurse Full Time; 8-5	Patient triage (phone & in person), in basket, RN Refill Protocol, Nurse Only visits, clinical resource for MAs.
3	Medical Receptionist (MR) Full Time/ shifts vary (plus a per diem)	Run front office, check patients in, process referrals, answer phones, process paperwork/faxes, schedule/cancel appointments
1	Patient Navigator Part Time	Interface with Ideal Options to assist with addiction resources for patients
1	Practice Manager Full Time- shared w IM Res	Run clinic operations, including finance, staffing, facilities, issues, patient complaints, issues, etc.
1	RN Clinical Supervisor Full Time- shared w IM Res	Assist with anything clinical, educates staff/providers, works closely with MA and RN in providing safe, quality patient care, patient complaints, issues, etc.

*Many employees are patients at our clinic, including some of our own staff. When medical care is being performed on a staff member, they cease being an employee and should be treated as any other patient. Please let the Practice Manager or RN Clinic Supervisor know if this becomes problematic.

Clinic Etiquette

Parking in the clinic parking lot is reserved for our patients.

Eating is not allowed in patient care areas. This includes all provider workstations unless in an office. Drinks are allowed but must have a lid.

The break room is available to all. Please be responsible and clean up after yourself. Clinic budget includes coffee, tea, sugar, utensils. Creamers, candy, etc are bought by staff or providers and generally shared with all. Put your name on any item in the fridge or on the table if it is not intended to be shared with others.

Secure your computer, even if walking away for a short time. Remember to Badge In, Badge Out.

Arrive at least 10 minutes early for your scheduled clinic time and be ready for the day, having prepared the night before or early that morning. Be respectful of your patients' time; do not make them wait. Clinic practice has been for the staff to write on the white board by the front desk so your patients know when you are running late and how far behind you are (in minutes).

There are many books, models, and a butterfly ultrasound in the clinic that are for all of the residents and students to use. If you take one of these home, please be sure to return it.

Communication

The more you communicate, the more smoothly the clinic will run. Don't hesitate to ask questions of staff, colleagues, leadership and/or faculty.

SRH email should be checked and responded to daily. This is official communication for the organization and the clinic. Communication related to patients should only be done daily in EPIC, not by email.

Cell phone calls or text messaging can be used in some situations. Consider using doximity to call from our clinic as opposed to blocking your number or calling directly from your cell.

Communication within Epic is addressed below.

Clinic Schedules

All changes to your clinic schedule must go through the Program Coordinator and Program Director. Please do not ask clinic staff to change your templates or schedules. Once approved, the PD or Coordinator will notify the clinic staff.

Clinic Teams

The goal is to have an MA assigned to work with each physician each shift. In scheduling the daily assignments of which MA works with which physician, the PGY1s are prioritized to work with their team MA, then PGY2, PGY3, and faculty. We feel this provides continuity which is more beneficial for early residents. Physicians should all huddle with their MA of the day at the start of each shift and go over their patients for that shift.

**Refer to the clinic teams handout*

Codes/ Emergencies

Overhead paging is not available at the residency clinic.

Although the ED is in close proximity, it is not appropriate to transport patients in any medical situation. An ambulance should be called to transport. This is for patient and staff safety and is SRH policy.

Epic In Basket/ Tasking

In Basket work is patient care! Work your tasks daily to avoid getting behind in responding to patient needs. After triaging and completing more urgent things, all In Basket tasks should still be completed within 48 hours. Please do not let tasks sit over the weekend.

EPIC Secure Chat can be used in certain circumstances to communicate with staff but it is not saved in the patient's record. All patient-related communication should be in an encounter (telephone encounter or staff message) so that it becomes a part of the patient's permanent medical record.

All communication to and from a patient or about a patient must be clearly and completely documented in an encounter in EPIC at the time. Document as soon as possible as accurate timelines can be important in the case of litigation. This includes every phone call. Document every attempt to contact a patient and if a message was left for someone to call back in a timely manner. This can be a critical component for patient communication, care, complaints and litigation.

Our program requires a Result Note documented on every result of a lab or imaging study, and that each patient is contacted via MyChart, letter, or phone call. This provides good closed-loop communication for patients as well as peers and supervisors reviewing the records.

Respond/ task to the front or back office pools with explicit information, written in layman's terms, along with any action the staff need to take. Staff are only able to read what you write to the patient. Only route messages that require action by office staff. Always route messages to the pools, not to an individual, unless provider to provider.

Have the patient scheduled for an appointment or call the patient yourself if the information is complex (writing a novel), a new diagnosis or multiple back and forth is needed.

Follow established In Basket workflows; ask for help if needed.

If there are specific patient scheduling issues identified that aren't urgent, please send a staff message via in basket and not an EPIC Secure Chat. Secure Chat is for urgent or same day issues.

Assigning coverage is required if you're away for more than a day at a time. Be sure to communicate with lead residents and put an away message on your in basket as well as secure chat when you're away for more than a day.

Paperwork/Faxes

Faxes/paperwork are patient care. Avoid getting behind in responding to patient needs. All patient care items should be addressed within 48 hours.

Every provider has a paper folder in the locked filing cabinet in the clinic for paperwork/faxes/mail. Check your folder/ ask and work with your MA to check your folder every time you are in the clinic and address all items promptly. If you are going to be away from the clinic, ask a colleague to assist with your folder.

Items to watch for: home health paperwork, nursing home certification (which is billable) and updates, DME certifications (we now use parachute online for DME).

Nurse visits

These are scheduled visits vs. walk in. All visits need to be signed off by a physician in the building at the time of the visit. Therefore, the patient may not be yours or part of your team. You may not interact at all with this patient; however a physician must be notified of all services rendered. Orders must be in the chart prior to the visit for them to be completed by the nurse (example- vaccines or testosterone injections).

We are a provider-based billing facility; therefore, clinical staff have to complete an acuity template for each patient (facility charge). Please note that the E/M codes for acuity template vs. E/M code for physicians are often very different. This is appropriate.

New / Established patients

New patients include: new to organization, new to department, or no visits for at least 3 years. Please follow trained workflows within Epic. All patients referred to us from the SRH Urgent Cares or other SRH FM clinics are considered established patients.

Referrals and Prior Authorizations

SRH has a centralized referrals department now. Please let them know via Epic Secure Chat message to their pool if there is a STAT referral request to prevent delay in processing. (Their work queue is only based on date entered, so they don't see the stats differently.)

Outpatient pharmacists will process Prior Authorization (PA) requests if they have all necessary information. Their contact information is on the contact list.

**Refer to the Res Clinics contact list*

Section 11- Technology Tips

Getting to SRH Intranet from home:

- Go to https://citrix.skagitregionalhealth.org/vpn/index.html
- You will need to have citrix to get here, it will help you install if you don't have it
- Log in with Windows username and Password
- Click SRH Intranet (you can use internet explorer or chrome [SRH Intranet – Chrome])

Getting to SRH Epic at home… (make sure you have Citrix as above)

- get VPN https://vpn.skagitregionalhealth.org/
- Install Cisco Anytime Connect (above link will guide you)
- Must connect to VPN First
- open this Link: http://epic-portal.et1005.epichosted.com/
- Click epic Icon, log in.
- When done, close Epic and then LOG OFF or CLOSE CISCO ANYTIME CONNECT (You don't want your private browsing history sent to Skagit!)

SRH Email:
http://mail.skagitvalleyhospital.org/

Standard SRH email signature instructions:

SRH Intranet - Document Details - Email Signature Photo Guidlines.pdf (myintranet.com)

Get your New-Innovations onto Outlook:

- Log into New Innovations
- Go to Scheduled > My Schedule
- In upper right, there is a blue link (above Saturday)
- Copy the iCalendar Subscription Link
- Go to your Email (Link above)
- Click Calendar
- Right click on “My Calendars” on the right (below the mini calendar)
- Select OPEN CALENDAR
- Paste Link from New Innovations into “Internet Calendar” Box
- Click OPEN

Setting up Email on iPhone

- Go to Settings
- Passwords and Accounts
- Add Account
- Microsoft Exchange
- Enter email (mine is: dhayes@skagitregionalhealth.org Yours should be first initial, last name @skagitregionalhealth.org or similar)
- In Description name what you want… mine is Skagit Email
- Click “Configure Manually”
- Enter Password
- For Server: mail.skagitvalleyhospital.org
- Domain: ahs
- Username: (what you use to log into windows!)
- Password: your windows password
- Say done

If you sync mail and Calendar you should now have New Innovations on your iphone calendar.

AMION:

Amion End User Guide Resident 202

Setting up UpToDate:

- Go to https://citrix.skagitregionalhealth.org/vpn/index.html and go to Intranet
- Go to UpToDate
- When you get here, you will see “Skagit Valley Hospital” In the upper right corner
- Click Register, create account, this will affiliate you with Skagit and let you sign in on your phone / ipad / home computer

Setting up Access Medicine:

- From intranet… go to https://accessmedicine.mhmedical.com/
- You should see “Skagit Regional Health” In upper right corner, Click this and select “sign in or create a free myaccess profile”
- This will let you create an affiliated account with Skagit

Setting up Johns Hopkins Antibiotic Guide

- From intranet browser… go to

https://www.unboundmedicine.com/ucentral/index/Johns_Hopkins_ABX_Guide/Diagnosis

- You will see Skagit Regional Health in the Right upper corner
- Click Sign In
- A box will pop up, click register
- Register for an account, you will then be able to get the app ("uCentral") on your phone / ipad or access on your home computer.

Dragon on your phone:
1. Download PowerMic Mobile from app store 2. Click this link:
http://powermicmobile.nuance.com/PowerMicMobile/253cfbd4-a448-4db0-ad88-7e99b6e3c98f/index.html
3. profile url: pms.nuancehdp.com
4. log-in with user name
5. Dragon has to be open and you select PowerMic Mobile as your microphone on the loading screen.

Doximity - app for doctors only
1. Free fax number
2. Free dialer, can make it seem like you're calling from the clinic