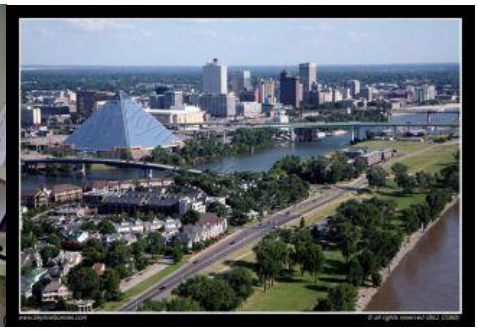
Baptist Memorial Hospital – Memphis and

Church Health

Family Medicine Residency Program

Program Handbook

2018 - 2019

UPDATED August 2018

Contents

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

BAPTIST®

Family Medicine

Primary Teaching Facilities

Baptist Memorial Hospital – Memphis

706 Licensed Beds

Baptist Memorial Hospital – Collierville

81 Licensed Beds

Baptist Memorial Hospital – DeSoto

339 Licensed Beds

Crosstown Building (rendering)

Church Health

Baptist Memorial Hospital for Women

140 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 cardiac or neurosciences. 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.

**2011 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.

LIBRARY CATALOG

PUBMED

SCIENCE DIRECT

ENCYCLOPEDIA BRITANNIA

COCHRANE LIBRARY (EBSCO)

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 (phPartners.org)

CDC Data and Statistics:

- BRFSS - Behavioral Risk Factor Surveillance System
- CDC WONDER (Wide-ranging Online Data for Epidemiologic Research)
- National Center for Health Statistics (NCHS) FastStats
- NHANES - National Health and Nutrition Examination Survey
- WISQARS – Web-based Injury Statistics Query and Reporting System

National Data and Reference Centers

- SAMHSA - Substance Abuse & Mental Health Services Administration
- Centers for Medicare and Medicaid Services (CMS)
- FedStats – U.S. Federal Statistics

State and Local Data Sets and Statistics:

- State Health Facts Online (Kaiser Family Foundation)
- US Census On the Move– Snap Shots of State Population Data

CHSI – Community Health Status Indicators

- America's Health Rankings (United Health Foundation)
- County Health Rankings and Roadmaps (Robert Wood Johnson Foundation)

International Statistics:

- World Health Organization – Statistical Information System (WHOSIS)
- Global Health Facts.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

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 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 form 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 our 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

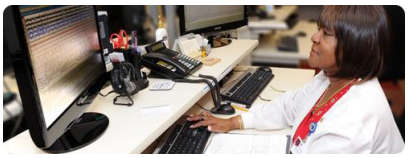
Baptist Memorial Hospital-Memphis offers extensive outpatient services for adults and pediatrics, ranging from basic diagnostic services and rehabilitation to advanced procedures, such as stem cell transplants.

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
- Blook 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
- Videofluroscopy 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)

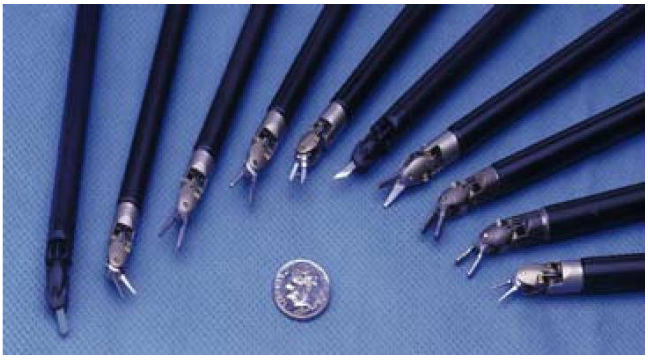
da Vinci Surgical System

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 Memphis surgeons have been specially trained to use the daVinci 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

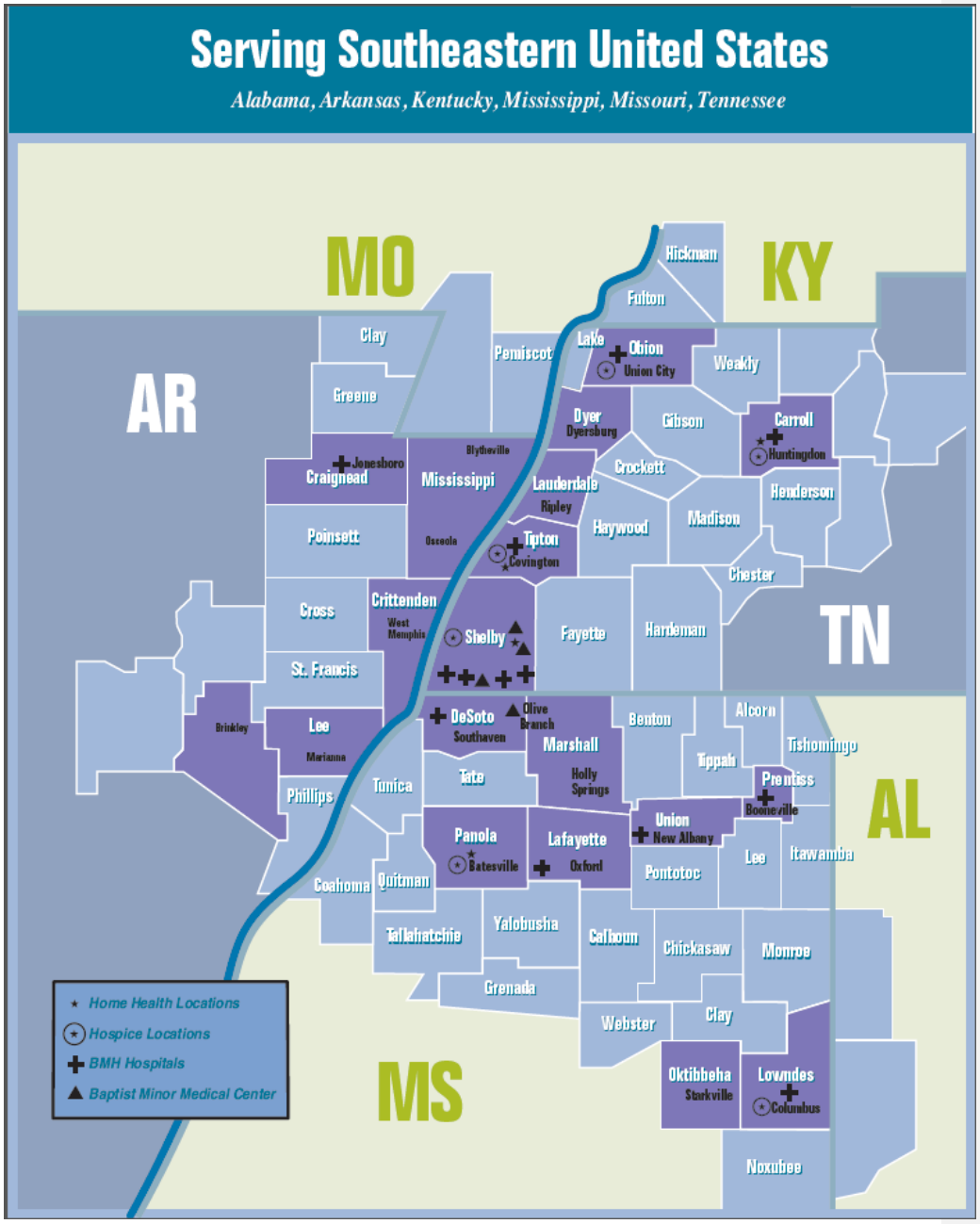
Knee/hip replacement classes

Interpretation services for hearing impaired and non-English speaking patients

Physician referral service

Wellness program

Baptist System Map



Letter of Commitment

BAPTIST.
Memorial Hospital
Memphis

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.

Derick 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

Family Medicine Practice (FMP) Profile

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.

Church Health

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).

Church Health

Our Leadership Team

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

Susan Nelson, M.D.
Medical Director

Ann Langston
Senior Director
Strategic Relationships &
Opportunities

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

Jennie Robbins
Senior Director
Finance and Performance

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;

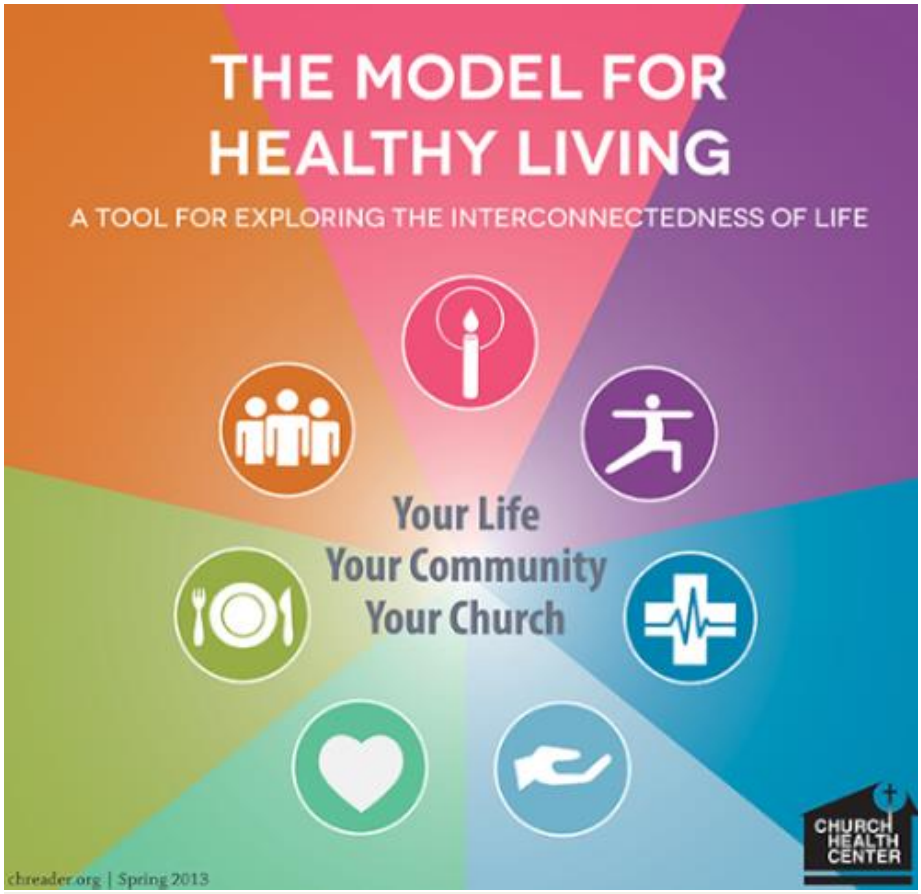
Whereas, the Center has been and continues to provide intern and scholar opportunities for people who want to gain experience and education working in the Center's ministries;

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.

Corporate Secretary



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?

	2016	2017	Increase
Medical Rooms	34	62	77%
Dental operatories	10	24	140%
Eye treatment rooms	4	15	300%
Counseling rooms	4	12	200%
Group exercise rooms	1	2	100%

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.

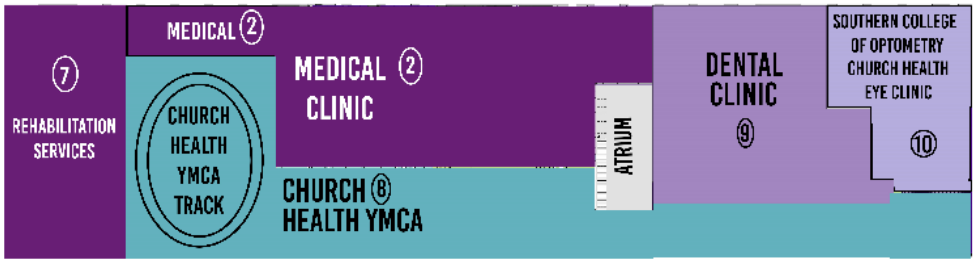
7. **Rehabilitation Services:** With a 50 percent increase in space for physical therapy, we will be able to provide better service to our patients recovering from illness or injury.

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

BAPTIST®

Graduate Medical Education

AY16/17 Resident Stipends

Effective Date: July 1, 2016

	July 2016 - June 2017 Basic Stipends	AAMC 25% South Region in AY15	AAMC Median South Region in AY15	AAMC 75th Percentile in AY15
PGY 1	$ 49,700.00	$ 48,024.00	$ 49,310.00	$ 51,146.00
PGY 2	$ 51,000.00	$ 49,547.00	$ 50,946.00	$ 52,573.00
PGY 3	$ 52,750.00	$ 50,988.00	$ 52,525.00	$ 54,579.00

Resident Stipends With Institution-Paid Health/Dental/Vison Insurance

	Employee	Spouse	Children	Family
PGY 1	$ 51,043.16	$ 52,540.50	$ 52,537.12	$ 53,531.62
PGY 2	$ 52,843.16	$ 54,340.50	$ 54,337.12	$ 55,331.62
PGY 3	$ 54,593.16	$ 56,090.50	$ 56,087.12	$ 57,081.62

BAPTIST OPERATIONS POLICY, PROCEDURE, AND GUIDELINE MANUAL

Effective Date: 3/87 **Last Revision: 10/11** **Last Reviewed: 11/04; 4/11; 10/14** **Reference #: S.AD.1028.01**	Patient Bill of Rights

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.

Baptist

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.

B. 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;

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

BAPTIST MEMORIAL HEALTH CARE CORPORATION

GRADUATE MEDICAL EDUCATION

DEPARTMENTAL POLICY AND PROCEDURE MANUAL

Effective Date: July 2013 **Last Review/Revision:** May 2016 **Reference #:** -	Resident Selection Guidelines and Applicant Eligibility

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.

BAPTIST MEMORIAL HEALTH CARE CORPORATION

GRADUATE MEDICAL EDUCATION

DEPARTMENTAL POLICY AND PROCEDURE MANUAL

Effective Date: July 2013 **Last Review/Revision: May 2016** **Reference #: -**	Resident Visa Policy

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.

BAPTIST

OPERATIONS POLICY, PROCEDURE AND GUIDELINE MANUAL

Effective Date: 1/95	Equal Employment Opportunity
Last Revision: 07/05; 9/08; 6/14 **Last Reviewed: 12/19/06, 12/10/07; 10/17/11**	
Reference #: S.HR.5003.03	

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. <u>Commitment to Equal Employment Opportunity</u>

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.

BAPTIST MEMORIAL HOSPITAL – MEMPHIS

GRADUATE MEDICAL EDUCATION

PROGRAM POLICY AND PROCEDURE MANUAL

Effective Date: January 2016	Resident Evaluation, Promotion and Discipline Policy
Last Review/Revision: February 2016	
Reference #: -	

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
    - 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.
    - 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
    - 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
    - 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
    - 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

BAPTIST MEMORIAL HEALTH CARE CORPORATION

GRADUATE MEDICAL EDUCATION

DEPARTMENTAL POLICY AND PROCEDURE MANUAL

Effective Date: July 2013	Resident Evaluation, Promotion and Discipline
Last Review/Revision: May 2016	
Reference #: -	

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:
    - Annual competency education (HealthStream)
    - Employee Health Requirements (TB, Flu, etc.)
    - 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

BAPTIST MEMORIAL HEALTH CARE CORPORATION

GRADUATE MEDICAL EDUCATION

DEPARTMENTAL POLICY AND PROCEDURE MANUAL

Effective Date: 7/1/2013 **Last Review/Revision:** May 2016 **Reference #:** -	Resident Salary

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 fulfil 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.

BAPTIST MEMORIAL HOSPITAL – MEMPHIS

GRADUATE MEDICAL EDUCATION

DEPARTMENTAL POLICY AND PROCEDURE MANUAL

Effective Date: July 2013	Nonrenewal of Agreements
Last Review/Revision: May 2016	
Reference #: -	

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 sub-contract, 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

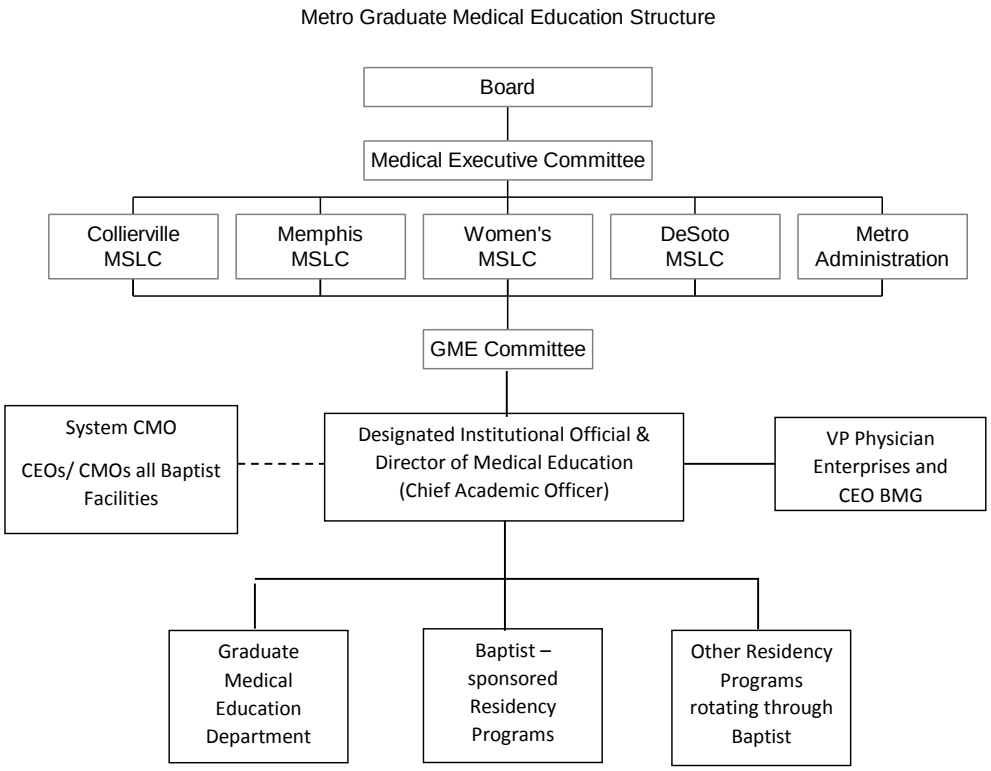
Resident

By:_____

Department and Program Structure

Organizational Charts

BMHCC Graduate Medical Education



Academic Year 2016 – 2017

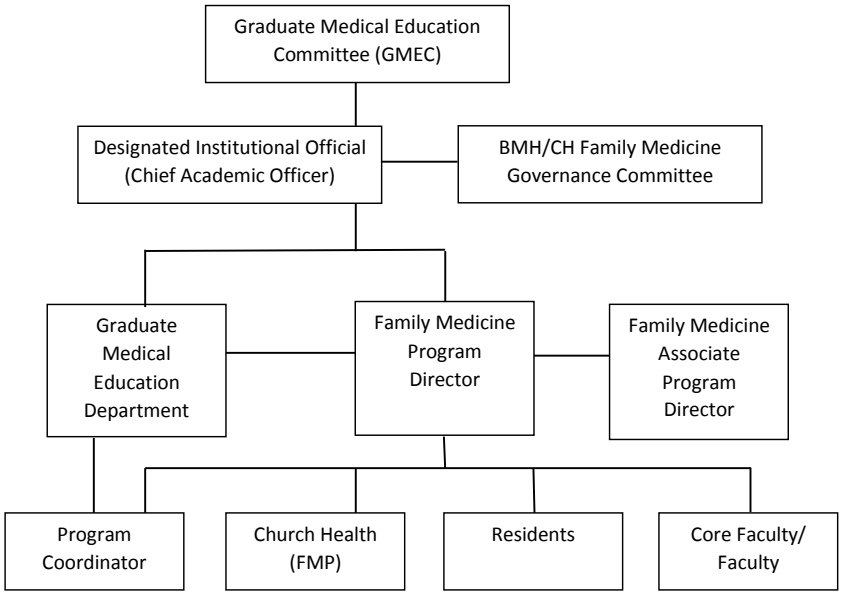
Family Medicine (ACGME # 1204700727)

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 programg(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
- Administrators from BMH-GT, BMH-M, BMH-NM, BMH-RC, BMH-W, BMH-J
- 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 and
    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.

BAPTIST MEMORIAL HOSPITAL – MEMPHIS

GRADUATE MEDICAL EDUCATION

DEPARTMENTAL POLICY AND PROCEDURE MANUAL

Effective Date: December 2013	GME Trainee Work Environment
Last Review/Revision: May 2016	
Reference #: -	

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.

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.

BAPTIST MEMORIAL HOSPITAL - MEMPHIS

GRADUATE MEDICAL EDUCATION

FAMILY MEDICINE POLICY AND PROCEDURE MANUAL

Effective Date: December 2014	Supervision Policy
Last Review/Revision: May 2016	
Reference #: -	

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

Patient Setting / Clinical Activity	**Initial Supervision Requirements:** Supervision requirements for all entry-level resident physicians is identified below.	**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.
Patient Setting / Clinical Activity	**Initial Supervision Requirements:** Supervision requirements for all entry-level resident physicians is identified below.	**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.
OPERATING / DELIVERY ROOM	**Direct Supervision** – The supervising physician is physically present with the resident/ student and patient.	**Direct Supervision** – The supervising physician is physically present with the resident/ student and patient.
NON-ROUTINE, NON-BEDSIDE, NON-OR PROCEDURES (e.g., Cardiac Cath, Endoscopy, Interventional Radiology, etc.)	**Direct Supervision** – The supervising physician is physically present with the resident/ student and patient.	**Direct Supervision** – The supervising physician is physically present with the resident/ student and patient.
EMERGENCY DEPARTMENT	**Direct Supervision** – The supervising physician is physically present with the resident/ student and patient.	**Direct Supervision** – The supervising physician is physically present with the resident/ student and patient.
EMERGENCY CARE - Immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted.	**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.	**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.

Patient Setting / Clinical Activity	**Initial Supervision Requirements:** Supervision requirements for all entry-level resident physicians is identified below.	**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.
INPATIENT CARE / New Admissions	**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.	**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.
INPATIENT CARE / Continuing Care	**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.	**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.
INPATIENT CARE / Intensive Care	**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.	**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.
INPATIENT CARE / Hospital Discharge and Transfers	**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.	**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.
OUTPATIENT CARE / New Patient Visit	**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.	**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.

Patient Setting / Clinical Activity	**Initial Supervision Requirements:** Supervision requirements for all entry-level resident physicians is identified below.	**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.
OUTPATIENT CARE / Return Patient Visit	**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.	**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.
OUTPATIENT CARE / Clinic Discharge	**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.	**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.
CONSULTATIONS - Inpatient, Outpatient, and Emergency Department	**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.	**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.
ROUTINE BEDSIDE and CLINIC PROCEDURES	**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.	**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.

BAPTIST MEMORIAL HEALTH CARE CORPORATION

GRADUATE MEDICAL EDUCATION

DEPARTMENTAL POLICY AND PROCEDURE MANUAL

Effective Date: July 2013	Duty Hours Policy
Last Review/Revision: May 2016	
Reference #: -	

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

BAPTIST MEMORIAL HEALTH CARE CORPORATION

GRADUATE MEDICAL EDUCATION

DEPARTMENTAL POLICY AND PROCEDURE MANUAL

Effective Date: July 2013	Moonlighting
Last Review/Revision: May 2016	
Reference #:	

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.

Baptist Memorial Health Care Corporation

Graduate Medical Education 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

BAPTIST MEMORIAL HEALTH CARE & CHURCH HEALTH

Family Medicine Residency Curriculum

BAPTIST MEMORIAL HEALTH CARE & CHURCH HEALTH

FAMILY MEDICINE RESIDENCY

CURRICULUM

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:

PG1

Objective	Measurement Tool	Expected Outcome
1. Perform a thorough history and physical examination	mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log	Meet expected competency level on rotation evals / Milestones
2. Synthesize data into a problem list and differential diagnosis	mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log	Meet expected competency level on rotation evals / Milestones
3. Formulate a diagnostic and therapeutic plan with some supervision	mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log	Meet expected competency level on rotation evals / Milestones

4. Demonstrate humanistic and professional behavior in patient interactions	mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log	Meet expected competency level on rotation evals / Milestones
5. Applies preventive care in an outpatient setting	mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log	Meet expected competency level on rotation evals / Milestones
6. Provide effective preventive health care and health care risk factor reduction to patients and their families	Direct observation, rotation eval / Milestones, chart review	Meet expected competency level on rotation evals / Milestones

PG2

Objective	Measurement Tool	Expected Outcome
1. Coordinate patient care among all members of the health care team	monthly global rating forms, patient and peer surveys, procedure logs	Meet expected competency level on rotation evals / Milestones; Meet institutional benchmarks on patient evals
2. Formulate therapeutic and diagnostic plan independently	monthly global rating forms, patient and peer surveys, procedure logs	Meet expected competency level on rotation evals / Milestones; Meet institutional benchmarks on patient evals
3. Use information technology to support patient care decisions	monthly global rating forms, patient and peer surveys, procedure logs	Meet expected competency level on rotation evals / Milestones; Meet institutional benchmarks on patient evals
4. Counsels and educates patients and families	monthly global rating forms, patient and peer surveys, procedure logs	Meet expected competency level on rotation evals / Milestones; Meet institutional benchmarks on patient evals
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	Direct observation, rotation evals / Milestones, patient evals	Meet expected competency level on rotation evals / Milestones; Meet institutional benchmarks on patient evals

PG3

Objective	Measurement Tool	Expected Outcome
1. Efficiently evaluate and manage patients in the inpatient and outpatient setting at the level of a family physician	monthly global rating forms, patient/peer/nurse surveys, procedure logs	Meet expected competency level for training on Rotation evals / Milestones

2. Function competently as an family medicine consultant	monthly global rating forms, patient/peer/nurse surveys, procedure logs	Meet expected competency level for training on Rotation evals / Milestones
3. Gather essential and accurate information using the following clinical skills: medical interviewing, physical examination, diagnostic studies, and developmental assessments	Direct observation, rotation evals / Milestones	Meet expected competency level for training on Rotation evals / Milestones
4. 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	Direct observation, rotation evals / Milestones	Meet expected competency level for training on Rotation evals / Milestones
5. 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.	Direct observation, rotations evals / Milestones	Meet expected competency level on rotation evals / Milestones
6. 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	Direct observation, rotation evals / Milestones, patient satisfaction surveys	Meet expected competency level on rotation evals / Milestones and meet institutional benchmarks on patient satisfaction surveys

	participate actively in the care plan		
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	Direct observation, patient survey, rotation eval / Milestones	Meet expected competency level on rotation evals / Milestones and meet institutional benchmarks on patient sat. surveys

Patient Care / Procedural Objectives

PG1

Objective	Measurement Tool	Expected Outcome
1. Perform the majority of procedures required by rotation specific curriculum	Direct observation, rotation evals, procedure evals	Attain competency level 2 - Able to perform this procedure with direct supervision and assistance

PG2

Objective	Measurement Tool	Expected Outcome
1. Perform and supervise procedures required by rotation specific curriculum	Direct observation, rotation evals, procedure evals	Attain competency level 3 - Able to perform this procedure without direct supervision

PG3

Objective	Measurement Tool	Expected Outcome
1. Perform and supervise every procedure required by rotation specific curriculum	Direct observation, rotation evals, procedure evals	Attain competency level 4 - Demonstrates a high level of technical skill and understanding of this procedure

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

Objective	Measurement Tool	Expected Outcome

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

Objective	Measurement Tool	Expected Outcome
1. Demonstrate in-depth 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 knowledge of medical literature analysis	in-service examination, monthly global rating forms, conference attendance log	Meet expectation competency level on rotation evals / Milestones: ITE exam

PG3

Objective	Measurement Tool	Expected Outcome
1. Demonstrate in-depth pathophysiology for commonly and uncommonly seen family medicine conditions	in-service examination, monthly global rating forms, conference attendance log	Meet expectation competency level on rotation evals / Milestones: ITE exam
2. Apply critical reading skills to current family medicine literature	in-service examination, monthly global rating forms, conference attendance log	Meet expectation competency level on rotation evals / Milestones: ITE exam
3. Develop a systematic approach to acquiring and maintaining current medical knowledge	in-service examination, monthly global rating forms, conference attendance log	Meet expectation competency level on rotation evals / Milestones: ITE exam
4. Critically evaluate current medical information and scientific evidence and modify one's knowledge base accordingly	Direct observation, conferences and journal reporting, Milestones	Satisfactory rotation evals, participate in and lead conferences, Milestones
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 life-long learning plans	Direct observation, rotation evals, Milestones, peer eval	Meet expected competency level on rotation evals / Milestones
6. Apply current medical information and scientific evidence effectively to	Direct observation, rotation evals /Milestones, peer evals	Meet expected competency level on evals / Milestones

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.

PG1

Objective	Measurement Tool	Expected Outcome
1. Ask for help when needed	Peer evals, PBLI project, Faculty eval / Milestones	Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones
2. Seek and accept feedback	Peer evals, PBLI project, Faculty eval / Milestones	Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones
3. Participate in quality improvement activities	Peer evals, PBLI project, Faculty eval / Milestones	Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones
4. Demonstrate improvement in clinical management	Peer evals, PBLI project, Faculty eval / Milestones	Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones
5. Teach M3 students effectively	Peer evals, PBLI project, Faculty eval / Milestones	Meet expected competency level on faculty and peer evals / Milestones

6. Demonstrate ability to access medically accurate web-based resources	Peer evals, PBLI project, Faculty eval / Milestones	Meet expected competency level on faculty and peer evals / Milestones

PG2

Objective	Measurement Tool	Expected Outcome
1. Teach interns and M4 students effectively	monthly global rating forms, peer evaluations, student evaluations	Meet expected competency level on faculty and peer evals / Milestones
2. Use patient care errors and near-misses to teach others	monthly global rating forms, peer evaluations, student evaluations	Meet expected competency level on faculty and peer evals / Milestones
3. Use information technology such as PubMed or Ovid to enhance patient care	monthly global rating forms, peer evaluations, student evaluations	Meet expected competency level on faculty and peer evals / Milestones
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	Population management projects in clinic, PBLI annual project	Meet goals or improve performance to meet benchmarks for chronic disease
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).	Mentor sessions, sign off all evals	Competency for level of training noted on Mentor/ Mentee summary sheets; satisfactory performance noted on evals / Milestones

PG3

Objective	Measurement Tool	Expected Outcome
1. Teach interns, students, and other residents effectively	Faculty evals / Milestones, Peer evals	Meet expected competency level on faculty and peer evals / Milestones
2. Analyze own practice for needed improvement	monthly global rating forms, peer evaluations	Meet expected competency level on faculty and peer evals / Milestones
3. Complete a QA/QI project under faculty direction	monthly global rating forms, peer evaluations	Meet expected competency level on faculty and peer evals / Milestones
4. Use scientific methods and evidence to investigate, evaluate, and improve one's own patient care practice;	Peer evals, PBLI project, Faculty eval / Milestones	Satisfactory performance on PBLI project annually, Meet expected competency level on Peer and Faculty evals / Milestones

	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 Evals/ 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

Objective	Measurement Tool	Expected Outcome
1. Present a case accurately and succinctly	monthly global rating forms (with chart audits), mini-CEXes, 360 degree evaluations including patient and student surveys	Satisfactory Performance on all evals/ Milestones: meet competency for level of training
2. Provide timely, legible, thorough, succinct medical record documentation - histories and physical examinations, progress notes, and discharge summaries	monthly global rating forms (with chart audits), mini-CEXes, 360 degree evaluations including patient and student surveys	Satisfactory Performance on all evals/ Milestones: meet competency for level of training

3. Work well within team context relating to students, attendings, other resident staff, nurses, and patients	monthly global rating forms (with chart audits), mini-CEXes, 360 degree evaluations including patient and student surveys	Satisfactory Performance on all evals/ Milestones: meet competency for level of training
4. Communicate and establish a therapeutic relationship with patients	monthly global rating forms (with chart audits), mini-CEXes, 360 degree evaluations including patient and student surveys	Satisfactory Performance on all evals/ Milestones: meet competency for level of training
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.	Peer Evals, 360° Evals	Satisfactory Performance on all evals/ Milestones: meet competency for level of training
6. Maintain comprehensive, timely, and legible medical records	Medical records/ transcription, delinquency reporting; chart review	Charts completed within 24 hours, no more than two delinquent notices per year from inpatients. medical records
7. Develop communication skills required to direct ACLS/PALS,NRP codes	Direct observation, nursing evals, preceptor evals	Satisfactory performance on all evals/ Milestones: meet expected competency level; successful completion of ACLS/PALS/NRP courses

PG2

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

PG3

Objective	Measurement Tool	Expected Outcome

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.

PG1

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

ethnicity, and sexual orientation		
13. Meet high standards of legal and ethical behavior.	360° Evals, Sign off on Professionalism contract	Satisfactory Performance on all evals/ Milestones: meeting competency for level of training
14. 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.	Mentor Sessions, Curricular Planning Documents, Monthly behavioral health support sessions, Attendance at lectures regarding sleep deprivation.	Sign and complete mentor Session documentation semiannually. Sign Curricular Planning Documents annually Successfully complete post-test following sleep deprivation lectures annually

PG2

Objective	Measurement Tool	Expected Outcome
1. Display initiative and leadership	monthly global rating forms, 360 degree evaluations	Satisfactory Performance on all evals/ Milestones: meeting competency for level of training
2. Delegate responsibility to others effectively	monthly global rating forms, 360 degree evaluations	Satisfactory Performance on all evals/ Milestones: meeting competency for level of training
3. Acknowledge errors and work to minimize them	monthly global rating forms, 360 degree evaluations	Satisfactory Performance on all evals/ Milestones: meeting competency for level of training

PG3

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

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.

PG1

Objective	Measurement Tool	Expected Outcome
1. Demonstrate ability to practice medicine in a private, government, and municipal hospital setting	monthly global rating forms, 360 degree evaluations, patient surveys	Satisfactory performance on all evals / attain institutional quality goals
2. Demonstrate ability to practice medicine in an ambulatory clinic	monthly global rating forms, 360 degree evaluations, patient surveys	Satisfactory performance on all evals / attain institutional quality goals
3. Function as a physician within a team	monthly global rating forms, 360 degree evaluations, patient surveys	Satisfactory performance on all evals / attain institutional quality goals
4. Serve as a patient advocate in the outpatient and inpatient setting	monthly global rating forms, 360 degree evaluations, patient surveys	Satisfactory performance on all evals / attain institutional quality goals
5. Work with ancillary team members (discharge planners, case managers, social workers) to provide high quality, cost-effective care	monthly global rating forms, 360 degree evaluations, patient surveys	Satisfactory performance on all evals / attain institutional quality goals
6. Advocate for the promotion of health and the prevention of disease and injury in populations.	Quality performance reports, HEDIS reports	Satisfactory performance on all evals / attain institutional quality goals

PG2

Objective	Measurement Tool	Expected Outcome
1. Direct care in inpatient and outpatient settings as a member of a multi-disciplinary team	monthly global rating forms, 360 degree evaluations, patient surveys	Satisfactory Performance on all evals/Milestones: meet competencies for level of training
2. Use systematic approaches to reduce errors	monthly global rating forms, 360 degree evaluations, patient surveys	Satisfactory Performance on all evals/Milestones: meet competencies for level of training

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

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

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	PGY1 at 6 months: Level 1.5 or greater
PGY 1 to 2: Level 2 or greater	PGY 2 at 6 months: Level 2.5 or greater
PGY 2 to3: Level 3 or greater	PGY 3 at 6 months: Level 3.5

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

Accreditation Council for Graduate Medical Education

Family Medicine Milestones

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

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

PC-2 Cares for patients with chronic conditions

Level 1	Level 2	Level 3	Level 4	Level 5

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 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	Level 2	Level 3	Level 4	Level 5
Collects family, social, and behavioral history Demonstrates awareness of recommendations for health maintenance and screening guidelines developed by various organizations	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	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	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	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	Level 2	Level 3	Level 4	Level 5
Acknowledges that patients with undifferentiated signs, symptoms, or health concerns are appropriate for the family physician and commits to addressing their concerns	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	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	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	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	Level 2	Level 3	Level 4	Level 5
Identifies procedures that family physicians perform	Performs procedures under supervision, and knows the indications of, contraindications	Uses appropriate resources to counsel the patient on the indications, contraindications,	Independently performs all procedures required for graduation	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	and complications of procedures 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	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

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates the capacity to improve medical knowledge through targeted study	Uses the American Board of Family Medicine (ABFM) In-Training Assessment resident scaled score to further guide his or her education Demonstrates capacity to assess and act on personal learning needs	Meets Maintenance of Certification (MOC) requirements in preparation for certification examination Achieves an ABFM In-Training Assessment resident scaled score predictive of passing the certification examination	Successfully completes ABFM requirements for certification Appropriately uses, performs, and interprets diagnostic tests and procedures	Maintains ABFM certification Demonstrates life-long learning beyond minimum MOC and Maintenance of Licensure (MOL) requirements

MK-2 Applies critical thinking skills in patient care

Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes that an in- depth knowledge of the patient and a broad knowledge of sciences are essential to the work of family physicians Demonstrates basic decision making capabilities Demonstrates the capacity to correctly interpret basic clinical tests and images	Synthesizes information from multiple resources to make clinical decisions Begins to integrate social and behavioral sciences with biomedical knowledge in patient care Anticipates expected and unexpected outcomes of the patients' clinical condition and data	Recognizes and reconciles knowledge of patient and medicine to act in patients' best interest Recognizes the effect of an individual's condition on families and populations	Integrates and synthesizes knowledge to make decisions in complex clinical situations Uses experience with patient panels to address population health	Integrates in-depth medical and personal knowledge of patient, family and community to decide, develop, and implement treatment plans 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

Level 1	Level 2	Level 3	Level 4	Level 5
Understands that health care resources and costs impact patients and the health care system	Knows and considers costs and risks/benefits of different treatment options in common situations	Coordinates individual patient care in a way that is sensitive to resource use, efficiency, and effectiveness	Partners with patients to consistently use resources efficiently and cost effectively in even the most complex and challenging cases	Role models and promotes efficient and cost-effective use of resources in the care of patients in all settings

SBP-2 Emphasizes patient safety

Level 1	Level 2	Level 3	Level 4	Level 5
Understands that medical errors affect patient health and safety, and that their occurrence varies across settings and between providers	Recognizes medical errors when they occur, including those that do not have adverse outcomes	Uses current methods of analysis to identify individual and system causes of medical errors common to family medicine	Consistently engages in self-directed and practice improvement activities that seek to identify and address medical errors and patient safety in daily practice	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
	Understands the mechanisms that cause medical errors			
Understands that effective team-based care plays a role in patient safety	Understands and follows protocols to promote patient safety and prevent medical errors	Develops individual improvement plan and participates in system improvement plans that promote patient safety and prevent medical errors	Fosters adherence to patient care protocols amongst team members that enhance patient safety and prevent medical errors	
	Participates in effective and safe hand-offs and transitions of care			

SBP-3 Advocates for individual and community health

Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes social context and environment, and how a community's public policy decisions affect individual and community health	Recognizes that family physicians can impact community health	Identifies specific community characteristics that impact specific patients' health	Collaborates with other practices, public health, and community-based organizations to educate the public, guide policies, and implement and evaluate community initiatives	Role-models active involvement in community education and policy change to improve the health of patients and communities
	Lists ways in which community characteristics and resources affect the health of patients and communities	Understands the process of conducting a community strengths and needs assessment		

			Seeks to improve the health care systems in which he or she practices	

SBP-4 Coordinates team-based care

Level 1	Level 2	Level 3	Level 4	Level 5
Understands that quality patient care requires coordination and teamwork, and participates as a respectful and effective team member	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	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	Accepts responsibility for the coordination of care, and directs appropriate teams to optimize the health of patients	Role models leadership, integration, and optimization of care teams to provide quality, individualized patient care

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

Level 1	Level 2	Level 3	Level 4	Level 5
Describes basic concepts in clinical epidemiology, biostatistics, and clinical reasoning	Identifies pros and cons of various study designs, associated types of bias, and patient-centered outcomes	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	Incorporates principles of evidence-based care and information mastery into clinical practice	Independently teaches and assesses evidence-based medicine and information mastery techniques
Categorizes the design of a research study	Formulates a searchable question from a clinical question	Critically evaluates information from others, including colleagues, experts, and pharmaceutical representatives, as well as patient-delivered information		
	Evaluates evidence-based point-of-care resources			

PBLI-2 Demonstrates self-directed learning

Level 1	Level 2	Level 3	Level 4	Level 5
Acknowledges gaps in personal knowledge and expertise and frequently asks for feedback	Incorporates feedback and evaluations to assess performance and develop a learning plan	Has a self-assessment and learning plan that demonstrates a balanced and accurate assessment of competence and areas for continued improvement	Identifies own clinical information needs based, in part, on the values and preferences of each patient	Regularly seeks to determine and maintain knowledge of best evidence supporting common practices, demonstrating consistent behavior of regularly reviewing evidence in common practice areas
Uses feedback to improve learning and performance	Uses point-of-care, evidence-based information and guidelines to answer clinical questions		Demonstrates use of a system or process for keeping up with relevant changes in medicine	Initiates or collaborates in research to fill knowledge gaps in family medicine
			Completes ABFM MOC requirements for residents	Integrates MOC into ongoing practice assessment and improvement
			Consistently evaluates self and practice, using appropriate evidence- based standards, to implement changes in practice	

			to improve patient care and its delivery	Role models continuous self-improvement and care delivery improvements using appropriate, current knowledge and best-practice standards

PBLI–3 Improves systems in which the physician provides care

Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes inefficiencies, inequities, variation, and quality gaps in health care delivery	Compares care provided by self and practice to external standards and identifies areas for improvement	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	Establishes protocols for continuous review and comparison of practice procedures and outcomes and implementing changes to address areas needing improvement	Role models continuous quality improvement of personal practice, as well as larger health systems or complex projects, using advanced methodologies and skill sets

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

Level 1	Level 2	Level 3	Level 4	Level 5
Defines professionalism Knows the basic principles of medical ethics Recognizes that conflicting personal and professional values exist Demonstrates honesty, integrity, and respect to patients and team members	Recognizes own conflicting personal and professional values Knows institutional and governmental regulations for the practice of medicine	Recognizes that physicians have an obligation to self-discipline and to self-regulate Engages in self-initiated pursuit of excellence	Embraces the professional responsibilities of being a family physician	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 Develops institutional and organizational strategies to protect and maintain these principles

PROF-2 Demonstrates professional conduct and accountability

Level 1	Level 2	Level 3	Level 4	Level 5
Presents him or herself in a respectful and professional manner Attends to responsibilities and completes duties as required Maintains patient confidentiality	Consistently recognizes limits of knowledge and asks for assistance Has insight into his or her own behavior and likely triggers for professionalism lapses, and is able to use this information to be professional Completes all clinical and administrative tasks promptly	Recognizes professionalism lapses in self and others Reports professionalism lapses using appropriate reporting procedures	Maintains appropriate professional behavior without external guidance Exhibits self-awareness, self-management, social awareness, and relationship management Negotiates professional lapses of the medical team	Models professional conduct placing the needs of each patient above self-interest Helps implement organizational policies to sustain medicine as a profession

Documents and reports clinical and administrative information truthfully	Identifies appropriate channels to report unprofessional behavior			

PROF-3 Demonstrates humanism and cultural proficiency

Level 1	Level 2	Level 3	Level 4	Level 5
Consistently demonstrates compassion, respect, and empathy Recognizes impact of culture on health and health behaviors	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 Elicits cultural factors from patients and families that impact health and health behaviors in the context of the biopsychosocial model Identifies own cultural framework that may impact patient interactions and decision-making	Incorporates patients' beliefs, values, and cultural practices in patient care plans Identifies health inequities and social determinants of health and their impact on individual and family health	Anticipates and develops a shared understanding of needs and desires with patients and families; works in partnership to meet those needs	Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health Develops organizational policies and education to support the application of these principles in the practice of medicine

PROF-4 Maintains emotional, physical, and mental health; and pursues continual personal and professional growth

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates awareness of the importance of maintenance of emotional, physical, and mental health Recognizes fatigue, sleep deprivation, and impairment	Applies basic principles of physician wellness and balance in life to adequately manage personal emotional, physical, and mental health Balances physician well-being with patient care needs	Actively seeks feedback and provides constructive feedback to others Recognizes signs of impairment in self and team members, and responds appropriately	Appropriately manages situations in which maintaining personal emotional, physical, and mental health are challenged	Optimizes professional responsibilities through the application of principles of physician wellness to the practice of medicine Maintains competency appropriate to scope of practice

Accepts constructive feedback

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	Level 2	Level 3	Level 4	Level 5
Recognizes that effective relationships are important to quality care	Creates a non-judgmental, safe environment to actively engage patients and families to share information and their perspectives	Effectively builds rapport with a growing panel of continuity patients and families Respects patients' autonomy in their health care decisions and clarifies patients' goals to provide care consistent with their values	Connects with patients and families in a continuous manner that fosters trust, respect, and understanding, including the ability to manage conflict	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	Level 2	Level 3	Level 4	Level 5
Recognizes that respectful communication is important to quality care Identifies physical, cultural, psychological, and social barriers to communication Uses the medical interview to establish rapport and facilitate patient-centered information exchange	Matches modality of communication to patient needs, health literacy, and context Organizes information to be shared with patients and families Participates in end-of-life discussions and delivery of bad news	Negotiates a visit agenda with the patient, and uses active and reflective listening to guide the visit Engages patients' perspectives in shared decision making Recognizes non-verbal cues and uses non-verbal communication skills in patient encounters	Educates and counsels patients and families in disease management and health promotion skills 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	Role models effective communication with patients, families, and the public Engages community partners to educate the public

C -3 Develops relationships and effectively communicates with physicians, other health professionals, and health care teams

Level 1	Level 2	Level 3	Level 4	Level 5
Understands the importance of the health care team and shows respect for the skills and contributions of others	Demonstrates consultative exchange that includes clear expectations and timely, appropriate exchange of information Presents and documents patient data in a clear, concise, and organized manner	Effectively uses Electronic Health Record (EHR) to exchange information among the health care team Communicates collaboratively with the health care team by listening attentively, sharing information, and giving and receiving constructive feedback	Sustains collaborative working relationships during complex and challenging situations, including transitions of care Effectively negotiates and manages conflict among members of the health care team in the best interest of the patient	Role models effective collaboration with other providers that emphasizes efficient patient-centered care

C-4 Utilizes technology to optimize communication

Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes effects of technology on information exchange and the physician/patient relationship Recognizes the ethical and legal implications of using technology to communicate in health care	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 Uses technology in a manner which enhances communication and does not interfere with the appropriate interaction with the patient	Ensures transitions of care are accurately documented, and optimizes communication across systems and continuums of care	Effectively and ethically uses all forms of communication, such as face-to-face, telephonic, electronic, and social media Uses technology to optimize continuity care of patients and transitions of care	Stays current with technology and adapts systems to improve communication with patients, other providers, and systems

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:

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 curretage
- Endometrial Biopsy and sampling
- Fracture management
- Hemorrhoid/Thrombus enucleation
- Incision and Drainage of Abscess, Cyst, Hematoma
- Joint Dislocation/Reduction (if able without conscious sedation)
    - Temporo-mandibular
    - 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

- Genital

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.

Specific Objective	Measurement Tool	Expected Outcome

BLS. ACLS protocols	BLS and ACLS courses	Passing Scores on ACLS course
PALS protocols	PALS training course	Pass PALS Course
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

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

• Breast lump • Disorders of Menstruation • Amenorrhea • Menopausal disorders • Menorrhagia and metrorrhagia		
Skin and Subcutaneous Diseases • Acne • Actinic keratosis • Cellulitis/abscesses • Contact dermatitis • Eczema • Ingrown nail • Onychomycosis • Psoriasis • Rosacea • Sebaceous cyst • Seborrheic keratosis • Skin ulcer • Urticaria	Direct Observation Annual In-service Training Exam	Meet expected competency level on Rotation Evaluation / Milestones
Musculoskeletal and Connective Tissue • Arthropathy • Fibromyalgia • Osteoarthritis • Osteoporosis • Rheumatoid arthritis • Synovitis • Pain in limb • Back pain • Cervical disorder • Rotator cuff / shoulder syndrome	Direct Observation Annual In-service Training Exam	Meet expected competency level on Rotation Evaluation / Milestones
Signs and Symptoms • Abdominal Pain • Abnormal pap • Arthralgia, unspecified • Rectal bleeding • Chest pain • Diarrhea • Dizziness • Dysphagia • Dysuria • Localized edema • Fatigue	Direct Observation Annual In-service Training Exam	Meet expected competency level on Rotation Evaluation / Milestones

• Feeding problem • Fever • Headache • Urinary incontinence and enuresis • Localized swelling or mass • Lymph nodes – enlarged • Nausea and or Vomiting • Pain in Knee • Palpitations • Polyuria • Rash, unspecified • Sensory disturbance of the skin • Shortness of breath (dyspnea) • Syncope • Urinary frequency • Weight loss		
Injuries and Adverse Effects • Ankle sprain • Foot sprain • Hand sprain • Leg sprain • Neck sprain • Shoulder and/or upper arm sprain • Wrist sprain • Abrasion • Contusion • Insect bite • Open Wound	Direct Observation Annual In-service Training Exam	Meet expected competency level on rotation eval / Milestones
Other Common Diagnoses • Contraception • Wound dressing • Exposure to an Infectious Disease • Immunization • Well Adult Check • Well Child Check	Direct observation Annual In-service Training Exam	Meet expected competency level on rotation eval / Milestones
Preventive Medicine Competencies: Coordinate preventive health care across providers, institutions and governmental agencies Demonstrate effective and compassionate communication with the patient and his/her family regarding reduction of risk factors and recommendations for screening and disease prevention.	Direct Observation Annual In-service Training Exam	Meet expected competency level on rotation eval / Milestones

Identify and access up-to-date, evidence based organizational resources and recommendations for health promotion and disease prevention. Demonstrate the acceptance of preventive health principles by modeling a healthy lifestyle. Perform a detailed history and physical exam with attention to healthy lifestyle promotion and disease prevention. Implement or use and existing system for patient recall in the outpatient setting for screening reminders. Advocate for patients within the current health care and continually strive toward system improvements to improve health maintenance and prevention of disease.		

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 form 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

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 inter-professional 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

- 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.

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, addictions, 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, addictions, 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, addictions (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.

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@bmg.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.

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

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

Interpersonal & Communication Skills	**SPECIALTY SPECIFIC OBJECTIVES**		
	See Family Medicine Objectives for a comprehensive list		
Professionalism	**SPECIALTY SPECIFIC OBJECTIVES**		
	See Family Medicine Objectives for a comprehensive list		
Systems-Based Practice	**SPECIALTY SPECIFIC OBJECTIVES**		
	See Family Medicine Objectives for a comprehensive list		

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

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@bmg.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.

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

- 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

- 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)
- Glascow 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@bmg.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.

C. The Electronic Textbook of Dermatology. Editor: Rhett Drugge, M.D. New York University http://www.telemedicine.org/stamfor1.htm
D. Atlas of Dermatology http://www.meddean.luc.edu/lumen/MedEd/medicine/dermatology/melton/atlas.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

- 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 rotatio
- Verify assigned shifts regarding upcoming rotation

Recommended Reading:

- Handbook of Diagnosis Status and Treatment in the Emergency Department
- Tintinalli's Emergency Medicine: A Comprehensive Study Guide, 8th ed., J. Tintinalli and J. Stapczynski
- 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
12. Nasal Packs: Anterior, Posterior
13. Dislocation reduction: Shoulder, Finger, Elbow, Hip
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 and practice of fluids 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:

- Harriet Lane Handbook, 20th ed., B. Enghorn and J. Flerlage
- Tintinalli's Emergency Medicine: A Comprehensive Study Guide, 8th ed., J. Tintinalli and J. Stapczynski
- Emergency Medicine Secrets, 6th ed., V. J. Markovchick
- Sanford Guide to Antimicrobial Therapy, 46th ed., D. Gilbert
- AFP articles on specific pediatric emergency topics

PATIENT CARE		
Specific Objective	**Measurement tool**	**Expected Outcome**
Learners will: • Provide compassionate, appropriate and effective care to children in the Pediatric Emergency Department • Demonstrate an ability to work inclusively with other health care professionals in the care of children with acute illnesses and injuries. • Discuss management of intravenous fluids in a dehydrated child • Participate in the care of patients with common pediatric conditions, such as, but not limited to: ➢ Asthma exacerbation ➢ Dehydration ➢ Gastroenteritis ➢ Febrile seizure ➢ Diabetic ketoacidosis ➢ Sprains, strains and fractures Motor vehicle collision or trauma	• Direct observation • Global (360°) evaluations	• Passing Scores on Rotation Evaluation
MEDICAL KNOWLEDGE		
Specific Objective	**Measurement tool**	**Expected Outcome**
Learners will be able to: • Use appropriate evidence-based resources to access information about care of routine conditions seen in the pediatric ED • Calculate intravenous fluid replacement for dehydrated infants and children • List the most common types of illness and injuries by age group • Discuss counseling strategies for pediatric safety (helmets; pads; seat belts; pool safety; gun safety) • Discuss common management strategies for the following: ➢ Asthma ➢ Pneumonia ➢ Febrile seizures ➢ Gastroenteritis ➢ Common childhood injuries/trauma ➢ Common sprains/strains/fractures ➢ Workup of suspected child abuse ➢ Urinary tract infection	• Direct observation • Global (360°) evaluations	• Passing Scores on Rotation Evaluation • Scores on resident in-training exam (ITE) which are above the national average for year of training
PRACTICE-BASED LEARNING AND IMPROVEMENT		
Specific Objective	**Measurement tool**	**Expected Outcome**
Learners will: • Demonstrate ability to incorporate new knowledge acquired from current guidelines and other evidence-based resources to patient care decisions • List and discuss quality control measures used in the Pediatric Emergency Department • Discuss the roles of various ED staff, including paramedics, triage personnel, nursing support, and physicians • Discuss how to contact poison control, child protective services, the rape and domestic violence counselors and other services available to children	• Direct observation • Global (360°) evaluations • Write-up of literature search of topic chosen by resident and endorsed by faculty	• Passing Scores on Rotation Evaluation

INTERPERSONAL AND COMMUNICATION SKILLS		
Specific Objective	**Measurement tool**	**Expected Outcome**
Learners will: • Demonstrate acceptable communication skills when interacting with staff, faculty, patients and students • Complete all exams, write-ups, orders and answer phone calls/pages in a time sensitive manner • Communicate effectively and in a patient-centered manner with patients and their families	• Direct observation • Global (360°) evaluations	• Passing Scores on Rotation Evaluation
PROFESSIONALISM		
Specific Objective	**Measurement tool**	**Expected Outcome**
Learners will: • Demonstrate compliance with confidentiality in all patient care interactions • Complete all charting, orders, procedure notes and answer all pages and requests in a timely fashion • Demonstrate appropriate working interactions with faculty, staff and students • Complete all written notes in legible form • Document all procedures in New Innovations at least weekly	• Direct observation • Global (360°) evaluations	• Passing Scores on Rotation Evaluation
SYSTEMS-BASED PRACTICE		
Specific Objective	**Measurement tool**	**Expected Outcome**
Learners will: • Discuss community and governmental programs for managing serious safety or welfare issues seen in the pediatric ED • Discuss and develop collegial working relationships with consultants and ED physicians • Provide counseling to at least three patients regarding safety practices (e.g. seat belts, play safety; pool safety; smoke detectors; smoke free environment)	• Direct observation • Global (360°) evaluations • Written reflection	• Passing Scores on Rotation Evaluation

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:

Demonstrates and Overall Approach to maintaining the health of a Geriatric Patient http://www.aafp.org/afp/20000215/1089.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates Knowledge and Use of Preventative Testing and Screening the in the Elderly http://www.fpronline.com/article.cfm?ID=399	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates an awareness of Sexuality in the Elderly http://www.apa.org/pi/aging/sexuality.html http://www.ejhs.org/volume8/sexuality_of_older_people.htm	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates the ability to assess a Geriatric Patient with Failure to Thrive http://www.aafp.org/afp/20040715/343.html	Direct Observation	Passing Scores on Rotation Evaluation
Fall risk assessment and prevention http://www.aafp.org/afp/20050701/81.html http://www.cdc.gov/ncipc/duip/FallsPreventionActivity.htm	Direct Observation	Passing Scores on Rotation Evaluation

http://www.temple.edu/older_adult/		
Demonstrates ability to diagnose and treat Dementia http://www.aafp.org/afp/20010215/703.html http://www.aafp.org/afp/20031001/1365.html http://www.aafp.org/afp/20020601/2263.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates Understanding of use Feeding Tubes in the elderly http://www.aafp.org/afp/20020415/1605.html http://www.medscape.com/viewarticle/420780	Direct Observation	Passing Scores on Rotation Evaluation
Understands Risk and ways to prevent polypharmacy http://www.aafp.org/afp/20021115/1917.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates and awareness of and appropriate devices to assist gait disorders in the elderly http://www.aafp.org/afp/20030415/1717.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates strategies for screening for elder or partner abuse http://www.nlm.nih.gov/medlineplus/elderabuse.html http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=6829&nbr=4196 http://www.annals.org/cgi/content/full/140/5/387	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates an awareness of Common Infections in older adults and is aware of the latest treatment recommendations http://www.aafp.org/afp/20010115/257.pdf	Direct Observation	Passing Scores on Rotation Evaluation
Treatment of UTI and asymptomatic bacteruria in the elderly http://www.aafp.org/afp/20060915/985.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates Strategy of Influenza Prevention in the Nursing Home http://www.aafp.org/afp/20020101/75.html	Direct Observation	Passing Scores on Rotation Evaluation
Is aware of strategies to Improve Patient Safety in Nursing Homes (Great Power Point Presentation) http://aging.utoronto.ca/sites/aging.utoronto.ca/files/Wagner.pdf	Direct Observation	Passing Scores on Rotation Evaluation
Is Competent at Performing Home Visits http://www.aafp.org/afp/991001ap/1481.html	Direct Observation	Passing Scores on Rotation Evaluation

http://www.aafp.org/fpm/20030700/69idoh.html		Submitted Encounter Form
Care of the Patient with PMR and/or Giant Cell Arteritis http://www.aafp.org/afp/20061101/1547.html	Direct Observation	Passing Scores on Rotation Evaluation
Diagnosis of Age Related Macular Degeneration http://www.aafp.org/afp/20000515/3035.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates ability to screen for and treat Osteoporosis *In Women* http://www.aafp.org/afp/20010301/897.html http://www.aafp.org/afp/20010315/1121.html http://www.aafp.org/afp/20000501/2731.html *In men* http://www.aafp.org/afp/20030401/1521.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates Management skills for Vertebral Compression Fractures http://www.aafp.org/afp/20040101/111.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates the ability to medically manage a hip fracture http://www.aafp.org/afp/20060615/2195.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates ability to diagnose and treat edema in the elderly http://www.aafp.org/afp/20050601/2111.html	Direct Observation	Passing Scores on Rotation Evaluation
Peripheral Vascular Disease http://www.aafp.org/afp/20060601/1971.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates ability to treat and manage erectile dysfunction http://www.aafp.org/afp/20000101/95.html	Direct Observation	Passing Scores on Rotation Evaluation
Lower Extremity Ulcers http://www.aafp.org/afp/20030815/tips/12.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates diagnostic and management skills related to abdominal pain in the elderly patient http://www.aafp.org/afp/20061101/1537.html	Direct Observation	Passing Scores on Rotation Evaluation

Diagnosis and management of osteoarthritis http://www.aafp.org/afp/20000315/1795.html	Direct Observation	Direct Observation
Familiar with 2ndary Prevention of Coronary Heart Disease in the Elderly http://www.aafp.org/afp/20050615/2289.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates ability to Diagnose and Treat Depression in the Elderly http://www.aafp.org/afp/20040515/2375.html http://www.aafp.org/afp/20020915/1001.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates strategies for pneumonia prevention and treatment in long term care facilities http://www.aafp.org/afp/20041015/1495.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates diagnostic and management skills for sleep disorders in the elderly http://www.aafp.org/afp/990501ap/2551.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates diagnostic and management skills for incontinence in the elderly http://www.aafp.org/afp/980600ap/weiss.html http://www.aafp.org/afp/20001201/2433.html	Direct Observation	Passing Scores on Rotation Evaluation
Demonstrates diagnostic and management skills for Herpes Zoster/Shingles http://www.aafp.org/afp/20050915/1075.html http://www.aafp.org/afp/20070615/steps.html	Direct Observation	Passing Scores on Rotation Evaluation
Management of SBE prophylaxis http://www.aafp.org/afp/980201ap/taubert.html	Direct Observation	Passing Scores on Rotation Evaluation
DVT diagnosis and treatment http://www.aafp.org/afp/20040615/2829.html http://www.aafp.org/afp/20040615/2841.html	Direct Observation	Passing Scores on Rotation Evaluation
Post-Operative Fever • Wind--pneumonia, atelectasis • Water--urinary tract infection • Wound--wound infections • Wonder drugs--especially anesthesia	Direct Observation	Passing Scores on Rotation Evaluation

• Walking--walking can help reduce deep vein thromboses and pulmonary embolus		
Dementia Screens http://www.aafp.org/afp/20010215/703.html http://www.clinicalgeriatrics.com/article/403 http://journals.cambridge.org/action/displayAbstract;jsessionid=C8F783A84B47036F41CB4BD8379B10E4.tomcat1?fromPage=online&aid=1359540 Fall Risk Screens http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_137818.pdf	Direct Observation	Passing Scores on Rotation Evaluation
Perioperative Medical Care http://www.surgical-tutor.org.uk/default-home.htm?principles/perioperative.htm~right	Direct Observation	Passing Scores on Rotation Evaluation
Pre-op cardiac assessment http://acc.org/qualityandscience/clinical/guidelines/perio/update/periupdate_index.htm Palm Program for Cardiac Clearance http://www.statcoder.com/cardiac1.htm	Direct Observation Chart Review	Passing Scores on Rotation Evaluation
Surgical Risk Assessment Appropriate use of pre-operative tests for elective surgery http://www.nice.org.uk/pdf/CG3NICEguideline.pdf	Direct Observation	Passing Scores on Rotation Evaluation
Parenteral Nutrition Management Complete this tutorial http://www.csun.edu/~cjh78264/parenteral/introduction.html	Direct Observation	Passing Scores on Rotation Evaluation
Blood Transfusion Guidelines http://www.guideline.gov/summary/summary.aspx?doc_id=9474	Direct Observation	Passing Scores on Rotation Evaluation
Transfusion Reaction Diagnosis and Management of http://www.emedicine.com/emerg/topic603.htm	Direct Observation	Passing Scores on Rotation Evaluation

*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)
4. The Johns Hopkins Manual of Gynecology and Obstetrics, Lippincott Williams & Wilkins, current edition
5. Managing Contraception handbook; current edition (available through CH)

PATIENT CARE		
Specific Objective	Measurement Tool	Expected Outcome
Learners will: • Provide compassionate, appropriate and effective care to women seeking gynecologic care • Demonstrate decision making in terms of which patients require referral to a gynecologist • Demonstrate the ability to perform a pap smear with bimanual exam, speculum exam, and clinical breast exam. • Demonstrate the ability to perform a wet prep and discuss common findings	Direct observation Global (360°) evaluations	Passing scores on rotation evaluations

• 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		
Specific objective	Measurement tool	Expected outcome
Learners will: • Discuss current guidelines for pap screening • Discuss current guidelines for breast cancer screening and mammography • Discuss common gynecologist cancers, including epidemiology, presentation, diagnosis and treatment options • Discuss common type of contraception, including diaphragms, cervical caps, condoms, IUD/IUS; and COCs • Discuss risk factors for intimate partner violence (IPV) and screening options for it • Discuss management/health care issues of patients who are lesbian, bisexual, or transgender • Discuss basic reproductive physiology • Discuss management strategies for dysfunctional uterine bleeding • Discuss diagnosis and management of the following common gynecologic conditions ▪ Breast diseases (benign and malignant) ▪ Amenorrhea/Ectopic pregnancy/unwanted pregnancy ▪ Gynecologic endocrinology (contraceptive methods, PCOS) ▪ Chronic pelvic pain, including endometriosis ▪ Menopause and hormone therapy ▪ Cervical cancer ▪ Vulvar and vaginal cancer ▪ Uterine cancer ▪ Ovarian cancer ▪ Urinary incontinence ▪ Osteoporosis ▪ Infections of the reproductive tract/vaginitis/PID ▪ Benign and malignant neoplasms		
PRACTICE-BASED LEARNING AND IMPROVEMENT		
Specific objective	Measurement tool	Expected outcome
Learners will: • Demonstrate the ability to search out current guidelines on women's routine health maintenance using online sources	Direct observation Global (360°) evaluations Write-up of literature search of topic chosen by resident and endorsed by faculty	Passing scores on rotation evaluations
INTERPERSONAL AND COMMUNICATION SKILLS		

Specific objective	Measurement tool	Expected outcome
Learners will: • Demonstrate acceptable communication skills when interacting with staff, faculty, patients and students • Complete all exams, write-ups, orders and answer phone calls/pages in a time sensitive manner • Communicate effectively and in a patient-centered manner with patients and their families	Direct observation Global (360°) evaluations	Passing scores on rotation evaluations
PROFESSIONALISM		
Specific objective	Measurement tool	Expected outcome
Learners will: • Demonstrate compliance with confidentiality in all patient care interactions • Complete all charting, orders, procedure notes and answer all pages and requests in a timely fashion • Demonstrate appropriate working interactions with faculty, staff and students • Complete all written notes in legible form • Document all procedures in New Innovations daily	Direct observation Global (360°) evaluations	Passing scores on rotation evaluations
SYSTEMS-BASED PRACTICE		
Specific objective	Measurement tool	Expected outcome
Learners will: • Participate in seminars at local systems that provide women's health care (women's shelter, IPV support groups, etc.) • List options for women who are victims of rape to receive care and/or shelter • Discuss how poverty, homelessness, immigrant status and access to contraception influence women's health care • Discuss gynecologic conditions which require referral to higher levels of care and how to establish/develop these specialist referral patterns	Direct observation Global (360°) evaluations	Passing scores on rotation evaluations

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.

Procedure	**Minimum number for competence**
Pap smear	10 and as observed by preceptor
Bartholin's cyst drainage/ Word catheter placement	Exposure and workshop discussion only
Colposcopy and biopsy	5 which include biopsy
LEEP	2 (elective)
Endometrial biopsy	2
IUD placement (Mirena & Paragard)	6 (3 each)

IUD removal	2
IUD location with ultrasound	2
Cervical polypectomy	1
Cryosurgery- cervix	3
Diaphragm fitting	1
Genital wart treatment	3

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

block, with group projects to be undertaken and mentored by Skip Steward, Director of Performance Improvement, BMHCC.

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:

   A. Read Dr. Morris' book: "God, Health and Happiness", Barbour Publishing, (originally released as Health Care You Can Live With: Discover Wholeness in Body and Spirit, January 2011).
   B. Attend Courses/classes at Wellness related to the Model.

C. Shadow a Health Coach seeing patients/members.

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

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 patients 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. C*linical Practice Guidelines for Quality Palliative Care* by the National Consensus Project for Quality Palliative Care: http://iweb.nhpco.org/iweb/Purchase/ProductDetail.aspx?Product_code=820538)

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:

    http://www.aafp.org/afp/20010215/703.html

    http://journals.cambridge.org/action/displayAbstract;jsessionid=C799224675EFFC11EEF4414D13C4AAC7.journals?aid=1814864&fileId=S1041610207006035

Additional Resources and Tutorials:

1. American Academy of Hospice and Palliative Medicine: http://www.aahpm.org/index.html
2. End-of-Life/Palliative Care Resources (one-page, peer-reviewed information summaries arranged by topic): http://www.aahpm.org/cgibin/wkcgi/search?fastfact=1&search=1
3. End of Life/Palliative Education Resource Center: http://www.eperc.mcw.edu/
4. National Guideline Clearinghouse: http://www.guideline.gov/
5. Up-To-Date: http://www.uptodate.com/
6. The Cochrane Library: http://www.cochrane.org/

7. Detailed Video Tutorial on Physical Exams Skills based on System: http://www.conntutorials.com/video.html
8. PDA tools: http://www.aahpm.org/physresources/pda.html

Competency Goals:

Patient and Family Care			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
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	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		Attending physician assessment of resident.
	1.1.2 Performs diagnostic workup; reviews primary source information and evaluation	Suggests plan of care, based on available information and prognosis, in consultation with attending physician.	Attending physician assessment of resident.
	1.1.3 Utilizes information technology; accesses on-line evidence-based medicine resources; uses electronic repositories of information, and medical records	Operates electronic information resources in a familiar manner	Attending physician assessment of resident.
1.2 Synthesizes and applies information in the clinical setting	1.2.1 Develops a prioritized differential diagnosis and problem list		Attending physician assessment of resident. Chart/record review
	1.2.2 Develops recommendations based on patient and family values	Integrates patient's and/or family's values into written goals of care and treatment plan	Family assessment of resident.
	1.2.3 Routinely obtains additional clinical information (from other physicians, nurses, pharmacists, social workers, case managers,	Collects information from other clinicians when needed	Team evaluation

Patient and Family Care			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	chaplains, respiratory therapists) when appropriate		
1.3 Demonstrates use of the interdisciplinary approach to develop a care plan that optimizes patient and family goals and reduces suffering			Team evaluation
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			Attending physician assessment of resident
1.5 Manages physical symptoms, psychological issues, social stressors, and spiritual aspects of the patient and family	1.5.1 Assesses pain and non-pain symptoms		Team evaluation
	1.5.2 Uses opioid and non-opioid pharmacologic options		Team evaluation
	1.5.3 Uses non-pharmacologic symptom interventions		Team evaluation
	1.5.4 Manages neuropsychiatric disorders		Team evaluation
	1.5.5 Manages physical symptoms and psychosocial and spiritual distress in the patient and family		Team evaluation
	1.5.6 Re-assesses symptoms frequently, and makes therapeutic adjustments as needed		Team evaluation
1.6 Provides care to patients and families that reflects unique characteristics of different settings along the palliative care spectrum	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		Team evaluation
	1.6.2 Delivers timely and accurate information and addresses barriers to patient and family access to palliative care in multiple settings		Team evaluation Pt/Family assessment of resident.

Patient and Family Care			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	1.6.3 Works with families in an interdisciplinary manner to formulate discharge plans for patients and families		Team evaluation Pt/Family assessment of resident.
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	1.7.1 Demonstrates a patient-family centered approach to care	Produces a patient and family-centered plan of care	Team evaluation Family assessment of resident.
	1.7.2 Makes recommendations to consulting physician(s) as appropriate	Formulates adequate palliative care recommendations; follows appropriate consult etiquette	Attending physician assessment of resident. Consultant assessment of resident.
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			Team evaluation Pt/Family assessment of resident.
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		Recognizes and respects patient's and family's uniqueness	Team evaluation Pt/Family assessment of resident.
1.10 Seeks to maximize patients' level of function, and quality of life for patients and families	1.10.1 Evaluates functional status over time	Uses appropriate tools to measure functional status	Team evaluation Chart/record review
	1.10.2 Evaluates quality of life over time	Documents quality of life in medical chart	Team evaluation Chart/record review

Patient and Family Care			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	1.10.3 Provides expertise in maximizing patient's level of function and quality of life	Refers to appropriate services	Team evaluation Chart/record review
	1.10.4 Seeks to preserve opportunities for individual and family life in the context of life-threatening illness		Pt/Family assessment of resident.
	1.10.5 Recognizes the potential value to patients and their family members of completing personal affairs/unfinished business	Identifies and facilitates opportunities to resolve unfinished issues	Team evaluation
	1.10.6 Effectively manages physical symptoms and psychosocial and spiritual distress in the patient and family		Team evaluation
1.11 Provides patient and family education	1.11.1 Educates families in maintaining and improving level of function to maximize quality of life		Team evaluation
	1.11.2 Explains palliative care services, recommendations and latest developments to patients and families		Team evaluation Pt/Family assessment of resident.
	1.11.3 Educates patient and family about disease trajectory and how and when to access palliation in future		Team evaluation
1.12 Recognizes signs and symptoms of impending death and cares for the imminently dying patient and their family members	1.12.1 Effectively prepares family, other health care professionals, and caregivers for the patient's death	Adequately interprets signs of impending death for other clinicians and family members	Team evaluation; Pt/Family assessment of resident.
	1.12.2 Provides assessment and symptom management for the imminently dying patient	Identifies transition to actively dying and changes management accordingly	Team evaluation
1.13 Provides treatment to the bereaved	1.13.1 Provides support to family members at the time of death and immediately after	Demonstrates compassion, expresses condolences, explores family questions, and provides information as desired by the family	Attending physician assessment of resident. Family assessment of resident. Team evaluation
	1.13.2 Involves interdisciplinary team members in treating the bereaved		Team evaluation

Patient and Family Care			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	1.13.3 Refers family members to bereavement programs	Knows available community resources	Team evaluation
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	1.14.1 Recognizes the need for collaboration with clinicians providing disease-modifying treatment		Attending physician assessment of resident. Resident self-assessment Consultant assessment of resident.
	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		Attending physician assessment of resident. Consultant assessment of resident.
	1.14.3 Accesses specialized pediatric and geriatric palliative care resources appropriately		Attending physician assessment of resident.
	1.14.4 Collaborates with other mental health clinicians to meet the needs of patients with major mental health issues	Integrates mental health clinicians' recommendations into patients' plans of care	Attending physician assessment of resident. Consultant assessment of resident.

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
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 Settings where hospice and palliative care are provided		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	Attending physician assessment of resident Chart/record review Team evaluation

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
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. The Medicare/Medicaid Hospice Benefit, including essential elements of the program, eligibility, and key regulations for all levels of hospice care Barriers faced by patients and families in accessing hospice and palliative care services		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	
2.2 Recognizes the role of the interdisciplinary team (IDT) in hospice and palliative care	2.2.1 Describes the role of the palliative care physician in the interdisciplinary team	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	Attending physician assessment of resident Team evaluation
	2.2.2 Identifies the various members of the interdisciplinary team and their roles and responsibilities	Describes the actual role of various clinicians on a team and evaluates their behaviors in terms of the potential roles they can play	Attending physician assessment of resident Team evaluation
	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	Demonstrates appropriate referral to allied health professionals in formulating and carrying out a care plan.	Attending physician assessment of resident Team evaluation
	2.2.4 Describes concepts of team process and recognizes psychosocial and organizational elements that promote or hinder	Describes team processes evident in a team meeting	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	successful interdisciplinary team function		
2.3 Describes how to assess and communicate prognosis	2.3.1 Identifies what elements of the patient's history and physical examination are critical to formulating prognosis for a given patient	In evaluating patients, identifies key elements (history, physical examination, and laboratory) that are useful in prognostication.	Attending physician assessment of resident
	2.3.2 Describes common chronic illnesses with prognostic factors, expected natural course and trajectories, common treatments, and complications	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	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	2.3.3 Describes effective strategies to communicate prognostic information to patients, families and health care providers	Uses clinical data to construct a prognosis, and then communicates this prognosis to a patient	Team evaluation
2.4 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	2.4.1 Identifies common diagnostic and treatment methods in the initial evaluation and ongoing management of cancer	In a variety of clinical situations in which metastatic disease is suspected, describes typical diagnostic efforts to confirm the diagnosis.	Attending physician assessment of resident
	2.4.2 Identifies common elements in prognostication for solid tumors and hematological malignancies at various stages, including the natural history of untreated cancers	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.	Attending physician assessment of resident
	2.4.3 Describes patterns of advanced disease, associated symptoms, and symptomatic treatments for common cancers	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	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
		efforts to delineate the etiology. For common presenting symptoms of advanced cancer (e.g, prostate cancer) describes symptomatic treatment	
	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	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	Attending physician assessment of resident
2.5 Recognizes the presentation and management of common non-cancer life-threatening conditions, including their epidemiology, evaluation, prognosis, treatment, patterns of disease progression, complications, emergencies, associated symptoms, and symptomatic treatments	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	In analyzing the presenting clinical data for patients with a variety of non-cancer life-threatening conditions, formulates a prognosis and eligibility for hospice	Attending physician assessment of resident
	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	Identifies common symptoms of advanced gastric cancer and describes symptomatic treatment. Provides a comprehensive evaluation for the symptoms associated with hypercalcemia and prescribes appropriate treatment	Attending physician assessment of resident
	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 for	Provides a comprehensive evaluation of advanced chronic lung disease, and prescribes or suggests appropriate management, including preparation for dealing with likely signs of	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	coronary artery disease and stroke for cerebrovascular disease	deterioration or the need for emergency care	
2.6 Explains principles of assessing pain and other common non-pain symptoms	2.6.1 Describes the concept of "total pain"	Provides a comprehensive analysis of patients with pain and identifies the physical, psychosocial, and spiritual components of distress	Attending physician assessment of resident
	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	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	Attending physician assessment of resident
	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	In evaluating patients, demonstrates an ability to assess and appropriately manage pain and other symptoms	Attending physician assessment of resident
	2.6.4 Names common patient, family, health care professional, and health care system barriers to the effective treatment of symptoms	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	Attending physician assessment of resident
2.7 Describes the use of opioids in pain and non-	2.7.1 Lists the indications, clinical pharmacology, alternate routes,	Demonstrates an ability to correctly prescribe opioids for pain and non-pain	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
pain symptom management	equianalgesic conversions, appropriate titration, toxicities, and management of common side effects for opioids	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	
	2.7.2 Describes appropriate opioid prescribing, monitoring of treatment outcomes, and toxicity management in chronic, urgent and emergency pain conditions.	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	Attending physician assessment of resident
	2.7.3 Describes appropriate opioid prescribing in different clinical care settings: home, residential hospice, hospital, long-term care facility	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	Attending physician assessment of resident
	2.7.4 Describes the concepts of addiction, pseudo-addiction, dependence and tolerance, and describes	For a patient in recovery from opioid abuse and now with pain from widely metastatic bony metastasis, counsels	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	their significance in pain management, as well as approaches to managing pain in patients with current or prior substance abuse	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	
	2.7.5 Explains the legal and regulatory issues surrounding opioid prescribing	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	Attending physician assessment of resident
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	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, anti-depressants, 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	Attending physician assessment of resident
2.9 Describes pharmacologic approaches to the management of common non-pain symptoms	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	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
		etiology of the delirium or at the symptom, including both pharmacological and nonpharmacological treatments	
	2.9.2 Identifies the indications, clinical pharmacology, alternate routes, appropriate titration, toxicities, and management of common side effects for: opioids, anxiolytics, antiemetics, laxatives, psychostimulants, corticosteroids, antidepressants, antihistamines, neuroleptics, sedatives and other common agents used in palliative care practice	Prescribes a satisfactory bowel regimen whenever prescribing opioids Prescribes benzodiazepines with an awareness of their half-lives, appropriate titration, and common toxicities Appropriately suggests neuroleptics for delirium and agitation, and is able to provide a rationale for use of particular agents	Attending physician assessment of resident
2.10 Describes the use of non-pharmacologic approaches to the management of pain and non-pain symptoms	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	In describing the diagnosis and treatment of pancreatic cancer, explains the role of celiac plexus block, complications, and usual outcomes	Attending physician assessment of resident
	2.10.2 Identifies indications, toxicities, management of common side effects, and appropriate referral for radiation therapy	Suggests the use of hypo-fractionated radiation therapy for selected patients with metastatic bone cancer	Attending physician assessment of resident
	2.10.3 Identifies indications, toxicities, and appropriate referral for commonly used complementary and alternative therapies, i.e. acupuncture, aromatherapy, guided imagery	For appropriately selected patients, explains and suggests relaxation exercises, and makes appropriate referrals	Attending physician assessment of resident
	2.10.4 Explains the role of allied health professions in pain and non-pain symptom management, such as speech, physical,	For patients with ALS at various stages of progression, is familiar with and able to prescribe appropriate use of speech,	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	respiratory, and occupational therapy	physical, respiratory, and occupational therapy	
2.11 Describes the etiology, pathophysiology, diagnosis, and management of common neuropsychiatric disorders encountered in palliative care practice, such as depression, delirium, seizures, and brain injury	2.11.1 Recognizes how to evaluate, and treat common neuropsychiatric disorders	Describes an organized, step-wise approach to evaluation and treatment of common neuropsychiatric disorders	Attending physician assessment of resident
	2.11.2 Describes how to refer appropriately to neurological and mental health professionals	Identifies triggers for referral to a neurologist or mental health professional	Attending physician assessment of resident
	2.11.3 Describes the indications, contraindications, pharmacology, appropriate prescribing practice, and side-effects of common psychiatric medications	Discusses the main indications and contraindications, basic pharmacology, appropriate prescribing practice, and main side effects of SSRIs, tricyclic antidepressants, anticonvulsants, benzodiazepenes, antipsychotics, barbiturates	Attending physician assessment of resident
	2.11.4 Recognizes the diagnostic criteria and management issues of brain death, persistent vegetative state, and minimally conscious state	Lists the diagnostic criteria for brain death and persistent vegetative state Describes common management issues around brain death and persistent vegetative state	Attending physician assessment of resident
2.12 Recognizes common psychological stressors and disorders experienced by patients and families facing life-threatening conditions, and describes appropriate clinical assessment and management.	2.12.1 Recognizes psychological distress	Identifies the presence of common psychological stressors Assesses for common physical and behavioral signs of psychological distress	Team evaluation
	2.12.2 Describes concepts of coping styles, psychological defenses, and developmental stages relevant to the evaluation	Lists and defines coping styles and psychological defenses	Team evaluation

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	and management of psychological distress	Identifies relevant coping styles and psychological defense mechanisms	
	2.12.3 Describes how to provide basic supportive counseling and to strengthen coping skills	Lists basic concepts of supportive counseling and strategies to strengthen coping skills	Team evaluation
	2.12.4 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	Routinely evaluates issues and needs of minor children involved in cases Demonstrates effective basic counseling and appropriate referral for minor children	Team evaluation
	2.12.5 Recognizes the needs of parents and siblings of children who are seriously ill or dying and provides appropriate basic counseling or referral	Routinely evaluates needs of siblings and parents when children are seriously ill Demonstrates effective basic counseling and appropriate referral for siblings and parents	Team evaluation
	2.12.6 Explains appropriate utilization of consultation with specialists in psychosocial assessment and management	Identifies common triggers for specialist consultation in the psychosocial domain	Team evaluation
2.13 Recognizes common social problems experienced by patients and families facing life-threatening conditions and describes appropriate clinical assessment and management	2.13.1 Able to assess, counsel, support, and make appropriate referrals to alleviate the burden of caregiving	Identifies signs of caregiver burden Explains strategies to relieve caregiver burden Routinely assesses for level of caregiver burden Refers appropriately to colleagues to address caregiver burden	Team evaluation
	2.13.2 Able to assess, provide support, and make appropriate referral around fiscal issues, insurance coverage, and legal concerns	Routinely assesses for distress around financial insurance, and legal concerns Refers appropriately to colleagues to address	Team evaluation

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
		financial, insurance and legal concerns	
2.14 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	2.14.1 Describes the role of hope, despair, meaning, and transcendence in the context of severe and chronic illness	Defines hope, despair, meaning and transcendence in a practical sense that promotes understanding for patients, families, and staff in this setting	Team evaluation
	2.14.2 Describes how to perform a basic spiritual/existential/religious evaluation	Explains an organized approach to covering basic elements of a spiritual/existential/religious history	Team evaluation
	2.14.3 Describes how to provide basic spiritual counseling	Defines basic principles of spiritual counseling and common scenarios where counseling could be of benefit	Team evaluation
	2.14.4 Identifies the indications for referral to chaplaincy or other spiritual counselors and resources	Lists indications for referral to chaplaincy or other spiritual resources	Team evaluation
	2.14.5 Knows the developmental processes, tasks, and variations of life completion and life closure	Describes common tasks of life closure for dying patients	Team evaluation
	2.14.6 Describes processes for facilitating growth and development in the context of advanced illness	Names strategies to facilitate growth and development for a patient with advanced illness	Team evaluation
2.15 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.	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	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	Team evaluation

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
		Demonstrates respect for and effort to honor diverse cultural values and customs	
2.16 Recognizes the components of management for the syndrome of imminent death	2.16.1 Identifies common symptoms, signs, complications and variations in the normal dying process and their management	Describes stages of dying, including common symptoms, signs, and complications, as well as relevant management strategies	Attending physician assessment of resident
	2.16.2 Describes strategies to communicate with patient and family about the dying process and to provide support	Identifies approaches for communicating with a patient and family about the dying process	Attending physician assessment of resident
2.17 Recognizes the elements of appropriate care of the patient and family at the time of death and immediately thereafter	2.17.1 Describes appropriate and sensitive pronouncement of death	Explains a step-wise process for death pronouncement, including personal preparation, patient assessment, family notification, and documentation	Attending physician assessment of resident
	2.17.2 Identifies the standard procedural components and psychosocial elements of post-death care	Describes post-death care, including family notification of death, autopsy option, organ donation option, funeral arrangements, routine care of the body, and death certificate completion	Attending physician assessment of resident
	2.17.3 Recognizes the potential importance and existence of post-death rituals and how to facilitate them	Routinely elicits and facilitates post-death rituals of importance to patients and families	Team evaluation
2.18 Describes the basic science, epidemiology, clinical features, natural course, stages, and management options for normal and pathologic grief	2.18.1 Demonstrates knowledge of normal grief and elements of bereavement follow-up, including assessment, treatment, and referral options for bereaved family members	Defines normal grief; lists elements of bereavement assessment; identifies approaches to bereavement treatment; explains local referral options for bereavement counseling	Attending physician assessment of resident
	2.18.2 Recognizes the risk factors, diagnostic features, epidemiology, and	Discuss risk factors, diagnostic features, and epidemiology of complicated grief and	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
	management of depression and complicated grief	depression associated with bereavement Identify management strategies for complicated grief and depression associated with bereavement	
	2.18.3. Appreciates risk of suicide in the bereaved and carries out initial assessment for suicide risk		Attending physician assessment of resident
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	2.19.1 Describes the epidemiology of pediatric life-threatening conditions	Names common causes of death for infants, children, and adolescents and the age ranges for these categories Discusses the difficulty of prognostication in the setting of rare syndromes and other congenital abnormalities in childhood and its relevance to clinical care	Attending physician assessment of resident
	2.19.2 Appreciates developmental perspectives on illness, grief, and loss	Explains common age-specific perspectives for patients and family members, as applied to illness, loss, and grief	Attending physician assessment of resident
	2.19.3 Describes pharmacologic principles applicable to the management of symptoms in infants, children, and adolescents	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	Attending physician assessment of resident

Medical Knowledge:			
Competency	**Sub-competency**	**Sample Behavior**	**Assessment Method**
2.20 Describes ethical and legal issues in palliative and end-of-life care and their clinical management	2.20.1 Discusses ethical principles and frameworks for addressing clinical issues	Explains common ethical principles and their application in palliative medicine Applies ethical principles to given ethical dilemma	Attending physician assessment of resident
	2.20.2 Describes federal, state, and local laws and practices that impact on palliative care practice	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	Attending physician assessment of resident Team evaluation
	2.20.3 Consults clinical ethicist appropriately	Explains local procedure for ethics consultation; identifies appropriate scenarios for ethics involvement	Attending physician assessment of resident
	2.20.4 Describes professional and institutional ethical policies relevant to palliative care practice	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	Attending physician assessment of resident

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.

Competency	**Required Skill(s)**	**Teaching Method(s)**	**Formative Evaluation Method(s)**
Patient Care	SPECIALTY SPECIFIC OBJECTIVES		
	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 • Febrile Neutropenia • Nosocomial and Community Acquired Pneumonia • Cellulitis • Chronic Wound Infections • Endocarditis • Infections in Solid Organ Transplant Patients • Multi-drug Resistant Organisms such as MRSA and VRE • Sepsis Syndrome • Meningitis • FUO	• ID Team Attending Rounds • ID Clinical Conference • Reading Lists	• Direct Feed-back & Mini-CEX • Praise/ Concern Cards • End-of-Rotation Evaluation

	Apply the principles of HIV/AIDS treatment: • Diagnosis of HIV • Initial Evaluation • Selection of Antiretroviral Agents • Prevention and Treatment of Opportunistic Infections	• ID Team Attending Rounds • ID Clinical Conference • Reading Lists • Core Curriculum Conference	• Direct Feed-back & Mini-CEX • Praise/ Concern Cards • End-of-Rotation Evaluation
	Describe the basic principles of hospital epidemiology: • Hand Hygiene • Isolation Guidelines	• ID Team Attending Rounds • ID Clinical Conference • Reading Lists • Core Curriculum Conference	• Direct Feed-back & Mini-CEX • Praise/ Concern Cards • End-of-Rotation Evaluation
	Evaluate and manage the common outpatient infectious disease problems of adults: • STDs • Diarrhea • Rashes	• ID Team Attending Rounds • ID Clinical Conference • Reading Lists • Core Curriculum Conference	• Direct Feed-back & Mini-CEX • Praise/ Concern Cards • End-of-Rotation Evaluation
	Describe emerging Infectious Diseases: • West Nile Virus • Bioterrorism	• ID Team Attending Rounds • ID Clinical Conference • Reading Lists • Core Curriculum Conference	• Direct Feed-back & Mini-CEX • Praise/ Concern Cards • End-of-Rotation Evaluation
	Develop expertise in patient care and the medical knowledge base required to manage the following aspects of Infectious diseases: • Febrile patients presenting with rash or FUO • Upper respiratory tract infections • Pleuropulmonary and bronchial infections. • Urinary tract infections • Peritonitis and other intra-abdominal infections • Cardiovascular infections • Central nervous system infections • Skin and soft tissue infections • Infections related to trauma, burns, and human and animal bites • Hastrointestinal infections and food poisoning syndromes • Bone and joint infections	• ID Team Attending Rounds • ID Clinical Conference • Reading Lists • Core Curriculum Conference	• Direct Feed-back & Mini-CEX • Praise/ Concern Cards • End-of-Rotation Evaluation

	• Infections of reproductive organs • Sexually transmitted diseases • Infections of the eye • Viral hepatitidies • Sepsis syndromes • Nosocomial infections • Infectious and non-infectious complications of HIV infection and acquired immunodeficiency syndrome • Infections in the immunocompromised or neutropenic hosts • Infections in acute leukemia and lymphoma • Transplant-related infections, including bone marrow and solid organ • Infections in geriatric patients • Infections in travelers • Infections related to intravenous drug abuse		
Medical Knowledge	SPECIALTY SPECIFIC OBJECTIVES		
	Demonstrate an understanding of the following: • Mechanism of action and adverse reactions to antimicrobial agents • Clinical pharmacology of antimicrobial agents • Assessing antimicrobial activity of drugs in appropriate clinical setting. • Recognize emerging infections/epidemics; principles and practice of hospital infection control. • Principles of chemoprophylaxis and immunoprophylaxis • Principles and practice of hospital control • Mechanisms of action of monoclonal antibodies, cytokines, interferons, interleukins, and colony-stimulating factors/applications; side effects • Introduce basic concepts of immunology, host defense mechanisms, • Utility of procedures for specimen collection relevant to ID including but not limited to bronchoscopy, thoracentesis, arthrocentesis, lumbar puncture, and aspiration of abscess cavities.	• ID Team Attending Rounds • ID Clinical Conference • Reading Lists • Core Curriculum Conference	• Direct Feed-back End-of-Rotation Evaluation • ITE/ABFM Board Exam sections on ID

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)

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.

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.

- 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 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

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

- 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

- 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
- 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

- 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

<u>Inpatient Chief (Senior) Resident responsibilities:</u>

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

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.

Specific Medical Knowledge Objective	**Method of Evaluation**	**Expected Outcome**
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. • 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	Direct observation	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

• Develop communication skills needed in patient hand-offs.
• Be aware of and utilize current literature in the management of inpatient problems.
• Realize time management strategies while functioning as a physician on an inpatient service.
• 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.
  • Regularly integrates medical facts and clinical data while weighing alternative and keeping in mind patient preference.
  • Presents current scientific evidence to support hypotheses.
  • Consistently monitors and follow-ups with patients appropriately.
  • 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.
  • Does not overly rely on tests or procedures.
  • Continuously revises assessments in the face of new data.
  • Tailors the therapeutic plan that takes into account discharge plan and outpatient resources.
• Pain Management:
  • Learns to properly assess pain as a presenting and/or accompanying symptom of hospitalized patients
  • 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.
  • Utilizes evidence-based recommendations to approach pain management.
• Patient Counseling:
  • Explains the advantages and disadvantages of competing therapeutic interventions.
  • Educates patient and families for enhanced compliance.
		(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	Direct observation	Satisfactory course eval and ITE scores; Milestone evaluation progression as above

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 insure they have complete knowledge of the process. One session is done each block or eight sessions over three years.	Direct Observation	Satisfactory Course Evaluation; Milestone evaluation progression as noted above

BMH/ CH Family Medicine Care of Infants and Children (Inpatient Pediatrics)

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

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:

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of **Fetal and neonatal period** 1. Risk factors determined by gestational age assessment 1. Effects of labor and delivery on the infant 2. Adaptations to extrauterine life 3. Newborn metabolic screening 4. Feeding/ Growth and caloric requirements 5. Sudden infant death syndrome (SIDS) 6. Diagnosis of congenital and genetic diseases 7. Diagnosis and role-appropriate management of: a. Meconium-stained amniotic fluid	Milestone Level 3-4 on end rotation evaluation ITE exam	

b. Perinatal asphyxia c. Respiratory distress d. Cyanosis e. Apnea f. Seizures g. Hypoglycemia h. Evaluations of possible sepsis i. Developmental dysplastic hip j. Birth-related injuries k. Neonatal abstinence syndrome (in utero drug exposure) l. Anemia m. Rh factor and blood type incompatibility n. Polycythemia o. Jaundice p. Premature and post-date gestations q. Maternal infections (HIV, hepatic etc)		
Demonstrates and Overall Approach to evaluating the health of a Neonate	Direct Observation	Milestone Level-3-4 on rotation end evaluation
Provide effective preventive health care and health care risk factor reduction to patients and their families.		
Counsel patients and their families about safe and effective care of their newborns.		
Describe the necessary medical equipment for neonatal resuscitation and demonstrate its proper use.		
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		

f. Oligo- or Polyhydramnios
g. Precipitous deliveries

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

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

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.

- 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 Inptient 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:

- 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
- Gastroesophageal reflux
- Food intolerance and malabsorption
- Pyloric stenosis
- Intussusception
- Appendicitis and peritonitis
- Recurrent and chronic abdominal pain
- Hernia
- Bilious emesis
- Hematemesis
- Hematochezia

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

- 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)

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

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

   a. Pudendal block may also be taught
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
14. Management of preterm labor and preterm premature rupture of membranes.
   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

c. Regionalized perinatal care for high-risk pregnancies
d. Collaboration with other health care providers

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.		
Patient Care	**Measurement Tool**	**Expected Outcome**
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. • Perform a comprehensive women's health history • Perform an adequately detailed OB intake visit • Present an adequately detailed OB intake visit to faculty • Discuss methods for accurate determination of gestational age • Measure fundal height appropriately • Demonstrate the ability to correctly determine gestational age using last menstrual period and/or early ultrasound • 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 • Discuss common indication for and contraindications to labor induction • Define and discuss the stages of labor	Direct observation Rotation Evaluation Patient Evaluation	Passing Scores on Rotation Evaluation Meeting Institutional Benchmarks on Patient Evaluations
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 • Demonstrate the ability to perform amniotomy, fetal scalp electrode placement, intrauterine pressure catheter placement (IUPC) • Demonstrate ability to manage labor induction with cervical ripening agents and labor augmentation using Pitocin	Direct observation Rotation Evaluation Skills check offs	Direct observation Passing Score Rotation Evaluation Passing score on clinical check offs

• 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	Direct Observation Rotation Evaluation Video taping	Demonstrating competency in counseling/decision making for level of training Passing scores on rotation evaluation
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 MFMs 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	Direct Observation Rotation Evaluations	Direct observation Passing Score Rotation Evaluations
Provide effective preventive health care and health care risk factor reduction to patients and their families.	Direct Observation Chart Review	Demonstrating competency in counseling/decision making Passing Scores on Rotation Evaluations

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 MFMs.

4. Meconium stained fluid
5. Management of group B strep positive mothers
6. Respiratory depression from:

   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		
Specific Objective	**Measurement Tool**	**Expected Outcome**
Learners will successfully complete the Advanced Life Support in Obstetrics (ALSO) course prior to participating in the rotation	ALSO Training Course	Passing Scores on ALSO course
<u>Diagnosis of Pregnancy/first trimester care</u> • 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	Morning Report Assessment on rounds Assessment at didactic based teaching sessions	
<u>Ante partum Care</u> • Learners will list commonly performed testing and surveillance during prenatal care, including time ranges for collection	Direct Observation Morning Report	Passing Scores on Rotation Evaluation

• 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 HTH; 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)		
<u>Labor and Delivery</u> 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	Direct Observation Morning Report	Passing Scores on Rotation Evaluation
<u>Obstetrical Prenatal Complications, diagnosis and management</u> 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	Direct Observation Morning Report	Passing Scores on Rotation Evaluation

9. Premature Rupture of Membranes 10. Abnormal Lies 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		
<u>Post-Partum care</u> 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 Edinborough depression screening tool • Discuss the importance of family centered maternity care and later family based care provided by family physicians	Direct Observation Morning Report	Passing Scores on Rotation Evaluation
PRACTICE-BASED LEARNING AND IMPROVEMENT		
Specific objective	Measurement tool	Expected outcome
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	Measurement tool	Expected outcome
Learners will: • Demonstrate acceptable communication skills when interacting with staff, faculty, patients and students		

• Complete all exams, write-ups, orders and answer phone calls/pages in a time sensitive manner • Communicate effectively and in a patient-centered manner with patients and their families		
PROFESSIONALISM		
Specific objective	Measurement tool	Expected outcome
Learners will: • Discuss and demonstrate how culture, age, language barriers, socioeconomic factors, and related issues can affect pregnancy management and newborn health issues. • Discuss confidentiality of patient information as it relates to issues of pregnancy and care of newborn. • Establish mutually respectful working relationships with all members of the maternity care and nursery care team.		
SYSTEMS-BASED PRACTICE		
Specific objective	Measurement tool	Expected outcome
Learners will: • Discuss how access to health care impacts perinatal and birth outcomes for both mothers and infants. • Describe the roles of midwives, nurse practitioners, doulas, obstetricians and family physicians in delivery of U.S. perinatal care. • Describe how a family-centered approach impacts patient and family experiences with maternity care systems. • List system safety practices that may improve perinatal and newborn outcomes.		

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.

Competency	**Required Skill(s)**	**Teaching Method(s)**	**Formative Evaluation Method(s)**
Patient Care	SPECIALTY SPECIFIC OBJECTIVES		
	Demonstrate proficiency in obtaining a neurological history and performing a neurological examination.	Clinical Teaching Conferences	Direct Feedback & Mini-CEX Praise/Concern cards End of Rotation Eval
	Distinguish neurological from non-neurological complaints	Clinical Teaching Conferences	Direct Feedback & Mini-CEX Praise/Concern cards End of Rotation Eval
	Localize the lesion anatomically	Clinical Teaching Conferences	
	Formulate a rational differential diagnosis, order appropriate laboratory and diagnostic tests, and effectively manage patients	Clinical Teaching Conferences	Direct Feedback & Mini-CEX Praise/Concern cards End of Rotation Eval

	Recognize neurological emergencies and call for help when needed	Clinical Teaching Conferences	Direct Feedback & Mini-CEX Praise/Concern cards End of Rotation Eval
	Interpret EEG, EMG and NCS, sleep studies, CT, MRI/MRA, myelogram, carotid ultrasound, and angiography reports correctly and apply properly to patient care	Clinical Teaching Conferences	Direct Feedback & Mini-CEX Praise/Concern cards End of Rotation Eval
	Demonstrate a basic knowledge of neuroanatomy permitting interpretation of at least non-contrasted and contrasted CT scans	Clinical Teaching Conferences	Direct Feedback & Mini-CEX Praise/Concern cards End of Rotation Eval
	Perform lumbar punctures, order the appropriate tests on the CSF, and correctly interpret the results	Clinical Teaching Conferences	Direct Feedback & Mini-CEX Praise/Concern cards End of Rotation Eval
	Describe how to perform and interpret the Tensilon test	Clinical Teaching Conferences	Direct Feedback & Mini-CEX Praise/Concern cards End of Rotation Eval
Medical Knowledge	SPECIALTY SPECIFIC OBJECTIVES		
	Demonstrate scholarship by citing references.	Clinical Teaching Conferences	Direct Feed-back, Mini-cex; praise/concern cardsEnd of Rotation Evaluation ITE /ABFM Board exam section on Neurology
	Identify the pathophysiology associated with each clinical condition encountered.	Clinical Teaching Conferences	Direct Feed-back, Mini-cex; praise/concern cardsEnd of Rotation Evaluation

			ITE /ABFM Board exam section on Neurology
	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	Clinical Teaching Conferences	Direct Feed-back, Mini-cex; praise/concern cardsEnd of Rotation Evaluation ITE /ABFM Board exam section on Neurology

Commented [KAL1]: 1. Changed font size

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/emermed/UNMStudentWebsite/PPT_Presentations/Splinting%20Lecture_files/frame.htm

Casting Techniques http://www.youtube.com/watch?v=eqxwise2m8I

Knee Injection http://www.aafp.org/afp/20021015/1497.html

Shoulder Injection http://www.aafp.org/afp/20030315/1271.html

Trochanteric Bursa Injection http://www.aafp.org/afp/20030515/2147.pdf

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_fractures

Nurse Maids Elbow http://www.wheelessonline.com/ortho/nursemaids_elbow_radial_head_subluxation

Humeral Factures http://wheelessonline.com/ortho/fractures_of_the_humerus

Radial/Ulna Fractures http://wheelessonline.com/ortho/fractures_of_the_radius

Schaphoid Fractures http://www.wheelessonline.com/ortho/scaphoid_scaphoid_fracture

Hand Fractures http://wheelessonline.com/ortho/hand_and_metacarpal_fractures

Finger Fracture/Phalangeal Fracture http://www.wheelessonline.com/ortho/phalangeal_fractures

Hip Fractures http://wheelessonline.com/ortho/hip_joint_index

Femur Factures http://wheelessonline.com/ortho/femoral_shaft_fracture

Tibial/Fibial Fractures http://wheelessonline.com/ortho/menu_for_the_tibia_tibia_frx

Ankle Fractures http://wheelessonline.com/ortho/__112

Foot Fractures http://wheelessonline.com/ortho/midfoot_forefoot_fractures

Rotation Specific Medical Knowledge Goals:

Osteoarthritis, Diagnosis and Management of http://www.aafp.org/afp/20020301/841.html
Tendon Injury/Overuse, Diagnosis and Management of http://www.aafp.org/afp/20050901/811.html
Use of Braces and Splints in Musculoskeletal Injury http://www.aafp.org/afp/20070201/342.html
Fracture Classification http://www.hughston.com/hha/a_14_2_1.htm
Fracture Diagnosis and Management of http://wheelessonline.com/ortho/trauma_fractures_index
Osteoporosis Diagnosis and Management of http://www.guideline.gov/summary/summary.aspx?doc_id=9626&nbr=5146
Cast Types and Maintenance of http://www.lpch.org/DiseaseHealthInfo/HealthLibrary/orthopaedics/casts.html
Finger Injuries, Diagnosis and Management of http://www.aafp.org/afp/20060301/810.html http://www.aafp.org/afp/20060301/827.html
Hand and Wrist Injuries, Diagnosis and Management of http://www.aafp.org/afp/20040415/1941.html http://www.aafp.org/afp/20040415/1949.html
Carpal Tunnel Syndrome, Diagnosis and Management of http://www.aafp.org/afp/20030715/265.html
Shoulder Pain/Injuries, Diagnosis and Management of https://inside.fammed.wisc.edu/education/musculo/index.html http://www.aafp.org/afp/20000515/3079.html http://www.aafp.org/afp/20000601/3291.html http://www.aafp.org/afp/20041115/1947.html
Rotator Cuff Tear/Injury:

Diagnosis of: http://www.aafp.org/afp/20050415/poc.html Management of: http://www.aafp.org/afp/980215ap/fongemie.html
Overuse Injuries of the Elbow http://www.aafp.org/afp/20000201/691.html
Hip Pain/Injuries, Diagnosis and Management of http://www.aafp.org/afp/991015ap/1687.html Hip Fracture, Diagnosis and Management of http://www.aafp.org/afp/20030201/537.html Hip Facture, MEDICAL MANAGEMENT of http://www.aafp.org/afp/20060615/2195.html Hip Pain in Athletes, Diagnosis and Management of http://www.aafp.org/afp/20000401/2109.html
Knee Pain/Injuries , Diagnosis and Management of https://inside.fammed.wisc.edu/education/musculo/index.html http://www.aafp.org/afp/20030901/907.html http://www.aafp.org/afp/20030901/917.html http://www.aafp.org/afp/991201ap/2599.html Knee monoarthritis, Diagnosis and Management of http://www.aafp.org/afp/20030701/83.html
Ankle Sprain, Diagnosis and Management of http://www.aafp.org/afp/20061115/1714.html
Heel Pain, Diagnosis and Management of http://www.aafp.org/afp/20040715/332.html
Toe Fractures, Diagnosis and Management of http://www.aafp.org/afp/20031215/2413.html
Lower Extremity Ulcers http://www.aafp.org/afp/20030815/tips/12.html
Musculoskeletal Pain in Children http://www.aafp.org/afp/20060701/115.html http://www.aafp.org/afp/20060715/293.html
Overuse injuries in Childhood/Adolescent Sports http://www.aafp.org/afp/20060315/1014.html

Anesthesia-Infilterative 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 http://www.nice.org.uk/pdf/CG3NICEguideline.pdf
Preoperative Antibiotic Guidelines http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9168761&dopt=Abstract Improving post-op surgical infections http://www.ihi.org/IHI/Topics/PatientSafety/SurgicalSiteInfections/
Blood Transfusion Guidelines http://www.guideline.gov/summary/summary.aspx?doc_id=9474

Transfusion Reaction Diagnosis and Management of http://www.emedicine.com/emerg/topic603.htm

*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

- 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 anteversion
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

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.

Competency	**Required Skill(s)**	**Teaching Method(s)**	**Formative Evaluation Method(s)**
Patient Care	SPECIALTY SPECIFIC OBJECTIVES		
	Assess the patient with the following rheumatologic complaints: • Monoarticular complaints • Polyarticular complaints • Myalgias • Low back pain • Carpal tunnel syndrome • Soft tissue rheumatism including regional periarticular • Syndromes (e.g., bursitis, tendonitis and fibromyalgia)	Clinical Teaching Conferences Reading List Case Presentations	Mini-CEX Praise/Concern cards End-of-Rotation Eval

	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
	  o Rheumatoid arthritis
	  o Osteoarthritis
	  o Spondyloarthropathies
	  o Crystal-induced arthropathies
	• Systemic Rheumatic diseases
	  o Systemic lupus erythematosus
	  o Inflammatory myopathies
	  o Systemic sclerosis and mixed connective tissue disease
	• Vasculopathies
	  o Giant cell arteritis and polymyalgia rheumatica
	  o Differential diagnosis of vasculitis fibromyalgia
		Clinical Teaching
		
		Conferences
		
		Reading List
		
		Case Presentations
			Mini-CEX
			
			Praise/Concern cards
			
			End-of-Rotation Eval

	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	Clinical Teaching Conferences Reading List Case Presentations	Mini-CEX Praise/Concern cards End-of-Rotation Eval

	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
	  o the shoulder, elbow, wrist, or knee joints
	  o the subacromial, olecranon, trochanteric, and anserine bursae
	  o the carpal tunnel
		Clinical Teaching
		
		Conferences
		
		Reading List
		
		Case Presentations
			Mini-CEX
			
			Praise/Concern cards
			
			End-of-Rotation Eval

Medical Knowledge	SPECIALTY SPECIFIC OBJECTIVES		

	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	Clinical Teaching Conferences Reading List Case Presentations	Mini-CEX Praise/Concern cards End-of-Rotation Eval ITE/ABFM Board Exam
	Describe the chronic nature of many rheumatic diseases, and their impact on patient/family quality of life including work, leisure/social, psychologic, sexual domains		Direct Feed-back Mini-CEX Praise/Concern cards End-of-Rotation Eval ITE/ABFM Board Exam
Practice Based Learning and Improvement	SPECIALTY SPECIFIC OBJECTIVES		
	See General Objectives for a comprehensive list.		
Interpersonal and Communication Skills	SPECIALTY SPECIFIC OBJECTIVES		
	See General Objectives for a comprehensive list.		
Professionalism	SPECIALTY SPECIFIC OBJECTIVES		
	See General Objectives for a comprehensive list.		
Systems-Based Practice	SPECIALTY SPECIFIC OBJECTIVES		
	See General Objectives for a comprehensive list.		

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

http://www.bumc.bu.edu/Dept/Content.aspx?DepartmentID=69&PageID=5913

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/SH/SkinHealth/brands/steri-strip/application/

Detailed instructions and video on a variety of incision types and surgical applications.

Incision and Drainage

Chest Tubes
http://www.webmedtechnology.com/physician/video.html

Central Lines
http://www.webmedtechnology.com/physician/video.html

PICC Lines
http://www.webmedtechnology.com/physician/video.html

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

Conscious Sedation http://www.webmedtechnology.com/physician/video.html

Nasogastric Tube Insertion

Interpretive Responsibilities

Chest x-ray

Pneumothorax

http://images.google.com/imgres?imgurl=http://www.med.yale.edu/intmed/cardio/imaging/findings/pneumothorax/graphics/rad1.gif&imgrefurl=http://www.med.yale.edu/intmed/cardio/imaging/findings/pneumothorax/index.html&h=386&w=473&sz=138&hl=en&start=3&tbnid=1J7oDuVEiBxSyM:&tbnh=105&tbnw=129&prev=/images%3Fq%3Dpneumothorax%26svnu m%3D10%26hl%3Den

ET tube/feeding tube placement x-ray

EKG/Rhythm Strips

Lab Values, related to acute abdomen

Abdominal x-ray Series

Free Air:

http://www.rad.msu.edu/Education/pages/Stu_Resources/Common/pages/Aben/IM_tutor/pages/top10/10.htm

http://sprojects.mmi.mcgill.ca/abdominalradiology/Cases/Case%202/index.htm

http://images.google.com/imgres?imgurl=http://www.ispub.com/xml/journals/ijfp/vol1n1/volvulus2.jpg&imgrefurl=http://www.ispub.com/ostia/index.php%3FxmlPrinter%3Dtrue%26xmlFilePath%3Djournals/ijfp/vol1n1/volvulus.xml&h=227&w=319&sz=6&hl=en&start=12&tbnid=usWBej8bPfM6VM:&tbnh=84&tbnw=118&prev=/images%3Fq%3Dfree%2Bair%2Bin%2Bthe%2Babdomen%26svnum%3D10%26hl%3Den%26rls%3DDMUS,DMUS:2006-39,DMUS:en

Small Bowel Obstruction

http://images.google.com/imgres?imgurl=http://www.learningradiology.com/caseofweek/caseoftheweekpix2006/cow216lg.jpg&imgrefurl=http://www.learningradiology.com/archives06/COW%2520216SBO/sbocorrect.htm&h=592&w=994&sz=81&hl=en&start=1&tbnid=WawiI3f2kk6dgM:&tbnh=89&tbnw=149&prev=/images%3Fq%3Dsmall%2Bbowel%2Bobstruction%26svnum%3D10%26hl%3Den%26rls%3DDMUS,DMUS:2006-39,DMUS:en

Large Bowel Obstruction

http://images.google.com/imgres?imgurl=http://www.learningradiology.com/caseofweek/caseoftheweekpix/cow87si_bysi.jpg&imgrefurl=http://www.learningradiology.com/archives04/COW%2520087Sigmoid%2520volvulus/sigmoidvolvcorrect.htm&h=640&w=1016&sz=97&hl=en&start=1&tbnid=jMWGNfic7EejM:&tbnh=94&tbnw=150&prev=/images%3Fq%3Dlarge%2B%2Bbowel%2Bobstruction%26svnum%3D10%26hl%3Den%26rls%3DDMUS,DMUS:2006-39,DMUS:en%26sa%3DG

GI Film Case Studies

http://images.google.com/imgres?imgurl=http://medinfo.ufl.edu/~abdimg/rad/img/normgas.jpg&imgrefurl=http://medinfo.ufl.edu/~abdimg/rad/page3.htm&h=509&w=419&sz=27&hl=en&start=9&tbnid=KnJFamFrLlUjJM:&tbnh=131&tbnw=108&prev=/images%3Fq%3Dlarge%2B%2Bbowel%2Bobstruction%26svnum%3D10%26hl%3Den%26rls%3DDMUS,DMUS:2006-39,DMUS:en%26sa%3DG

Rotation Specific Medical Knowledge Goals:

Medical Knowledge		
Overall Goal: Become competent assessing patients for possible surgery.		
Specific Objective	Measurement Tool	Expected Outcome
Cancer Staging TNM method http://www.cancer.gov/cancertopics/factsheet/Detection/staging	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Acute Abdomen (Diagnosis of and treatment of) http://www.aafp.org/afp/20030601/2321.pdf (children) http://www.aafp.org/afp/20061101/1537.html (adults)	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Appendicitis Diagnosis and Management http://www.aafp.org/afp/20050101/71.html http://www.aafp.org/afp/991101ap/2027.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Abdominal Wall Pain Diagnosis and Management http://www.aafp.org/afp/20010801/431.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Jaundice in the Adult Patient Diagnosis and Management http://www.aafp.org/afp/20040115/299.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Acute Pancreatitis Diagnosis and Management http://www.aafp.org/afp/20000701/164.html	Direct Observation	Milestone Level 3-4 on Rotation end evaluation
Chronic Pancreatitis Diagnosis and Management http://www.emedicine.com/MED/topic1721.htm	Direct Observation	Milestone Level 3-4 on Rotation end evaluation
Management of Gallstones http://www.aafp.org/afp/20050815/637.html	Direct Observation	Milestone Level 3-4 on Rotation end evaluation
Ileus Newborn http://www.aafp.org/afp/20000501/2791.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation

Small Bowel Obstruction Diagnosis and Management http://www.emedicine.com/EMERG/topic66.htm	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Large Bowel Obstruction Diagnosis and Management http://www.emedicine.com/emerg/topic65.htm	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Colon Cancer Screening Guidelines http://www.ahrq.gov/clinic/3rduspstf/colorectal/colorr.htm http://www.guideline.gov/summary/summary.aspx?doc_id=3686	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Colon Polyp Types and Management http://www.askasge.org/pages/brochures/polyps_brochure.cfm http://www.aafp.org/afp/20000315/1759.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Diverticular Disease Diagnosis and Treatment: http://www.aafp.org/afp/20051001/1229.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Breast Cancer Screening Guidelines http://www.guideline.gov/summary/summary.aspx?doc_id=3745	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Breast Cancer Management http://www.cancer.gov/cancertopics/pdq/treatment/breast/Patient	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Peripheral Vascular Disease http://www.aafp.org/afp/20060601/1971.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Vascular Surgery Indications (Carotids, aneurysms, PVOD) http://www.aafp.org/afp/20070101/85.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Lower Extremity Ulcers http://www.aafp.org/afp/20030815/tips/12.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Hernia Management and Treatment Groin http://www.aafp.org/afp/990101ap/143.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation

http://www.nlm.nih.gov/medlineplus/tutorials/inguinalhernia/htm/index.htm Incisional http://www.nlm.nih.gov/medlineplus/tutorials/incisionalhernia/htm/lesson.htm		
Wound Care http://www.emedicine.com/med/topic2754.htm Phases of Wound Healing http://www.surgical-tutor.org.uk/default-home.htm?sciences/pathology/wound_healing.htm~right http://www.surgical-tutor.org.uk/default-home.htm?core/preop2/healing.htm~right http://www.medicaledu.com/phases.htm Wound Etiology/Types of Ulcers http://www.medicaledu.com/etiology.htm Ulcer Staging http://www.medicaledu.com/staging.htm Clinical Guidelines for Wound Ulcer Treatment http://www.medicaledu.com/ahcpr.htm Wound Care Products http://www.medicaledu.com/prodindx.htm Wound Care Orders http://www.medicaledu.com/orders.htm Sources of Wound infections http://www.surgical-tutor.org.uk/default-home.htm?principles/microbiology/wound_infection.htm~right Scars and Contractures http://www.surgical-tutor.org.uk/default-home.htm?core/preop2/scars.htm~right	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Suture Types http://www.surgical-tutor.org.uk/default-home.htm?core/preop2/sutures.htm~right	Direct Observation	Milestone Level 3-4 on rotation end evaluation

Aseptic Technique http://www.surgical-tutor.org.uk/default-home.htm?core/preop1/asepsis.htm~right	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Surgical Drains http://www.surgical-tutor.org.uk/default-home.htm?core/preop1/surgical_drains.htm~right	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Anesthesia-Infilterative 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	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Perioperative Pain Management http://www.asahq.org/publicationsAndServices/pain.pdf (Cancer Patients) http://www.asahq.org/publicationsAndServices/cancer.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Management of SBE prophylaxis http://www.aafp.org/afp/980201ap/taubert.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
DVT diagnosis and treatment http://www.aafp.org/afp/20040615/2829.html http://www.aafp.org/afp/20040615/2841.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
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	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Postoperative Medical Care: http://www.surgical-tutor.org.uk/default-home.htm?intercollegiate.htm~right	Direct Observation	Milestone Level 3-4 on rotation end evaluation

Perioperative Medical Care http://www.surgical-tutor.org.uk/default-home.htm?principles/perioperative.htm~right	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Pre-op cardiac assessment http://acc.org/qualityandscience/clinical/guidelines/perio/update/periupdate_index.htm Palm Program for Cardiac Clearance http://www.statcoder.com/cardiac1.htm	Direct Observation Chart Review	Milestone Level 3-4 on rotation end evaluation
Surgical Risk Assessment Appropriate use of pre-operative tests for elective surgery http://www.nice.org.uk/pdf/CG3NICEguideline.pdf	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Surgical Preps Bowel http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=9619&nbr=5139 http://www.sages.org/sagespublication.php?doc=BOWEL	Direct Observation Chart Review	Milestone Level 3-4 on rotation end evaluation
Preoperative Antibiotic Guidelines http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9168761&dopt=Abstract Improving post-op surgical infections http://www.ihi.org/IHI/Topics/PatientSafety/SurgicalSiteInfections/	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Parenteral Nutrition Management Complete this tutorial http://www.csun.edu/~cjh78264/parenteral/introduction.html	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Blood Transfusion Guidelines http://www.guideline.gov/summary/summary.aspx?doc_id=9474	Direct Observation	Milestone Level 3-4 on rotation end evaluation
Transfusion Reaction Diagnosis and Management of http://www.emedicine.com/emerg/topic603.htm	Direct Observation	Milestone Level 3-4 on rotation end evaluation

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

Tympanograms http://www.aafp.org/afp/20041101/1713.html

Cerumen removal—with loop and/or irrigation

Rinne and Weber tests http://www.aafp.org/afp/20000501/2749.html

Placement of ear wick

Urinary catheterization

Urodynamic studies http://www.aafp.org/afp/980600ap/weiss.html

Vasectomy http://www.aafp.org/afp/20061215/2069.html

General Interpretive Responsibilities:

Sinus Films/CT

Glaucoma indicators/pressure reading

Uro-dynamic Studies http://www.aafp.org/afp/980600ap/weiss.htm

Tympanogram http://www.aafp.org/afp/20041101/1713.html

Audiology results	http://www.aafp.org/afp/20000501/2749.htm
Bladder Scans	
PSA results	
Semen analysis	http://www.aafp.org/afp/20020615/practice.html

Rotation Specific Medical Knowledge Goals:

Urology Specific Knowledge Based Competency		
Specific goal	Measurement Tool	Expected Outcome
Understands growth and development of male anatomy	Direct observation	Satisfactory course evaluation (Milestone Level 3-4)
Dysuria work up http://www.aafp.org/afp/20020415/1589.html	*Direct Observation	Satisfactory Course Evaluation
Acute Scrotum http://www.aafp.org/afp/990215ap/817.html	*Direct Observation	Satisfactory Course Evaluation
Diagnosis and treatment of STD's http://www.cdc.gov/std/treatment/2006/rr5511.pdf	*Direct Observation	Satisfactory Course Evaluation
Diagnosis and treatment of Urethritis		
Diagnosis and treatment of Epididymitis		
Diagnosis and treatment of Orchitis http://www.aafp.org/afp/980215ap/junnila.html	*Direct Observation	Satisfactory Course Evaluation
Diagnosis and treatment of Prostatitis http://www.aafp.org/afp/20000515/3015.html	*Direct Observation	Satisfactory Course Evaluation
Penile abnormalities Peyronies http://www.aafp.org/afp/990800ap/549.html Phimosis/paraphimosis http://www.aafp.org/afp/20001215/2623.html Epispadias/hypospadias	*Direct Observation	Satisfactory Course Evaluation
Scrotal abnormalities	*Direct Observation	Satisfactory Course Evaluation

Undescended testicle http://www.aafp.org/afp/20001101/2037.html Hydroceles Spermatoceles http://www.aafp.org/afp/980215ap/junnila.html Varicoceles http://www.auanet.org/guidelines/main_reports/varicoceleinfertility.pdf Epididymis cysts		
Urinary Obstruction BPH http://www.auanet.org/guidelines/bph.cfm Urethral. Stricture	*Direct Observation	Satisfactory Course Evaluation
Cystitis/UTI http://www.aafp.org/afp/990301ap/1225.html http://www.aafp.org/afp/990315ap/1472.html http://www.aafp.org/afp/20000201/713.html http://www.aafp.org/afp/20020515/tips/3.html	*Direct Observation	Satisfactory Course Evaluation
Bladder Dysfunction Enuresis http://www.aafp.org/afp/20030401/1499.html Incontinence http://www.aafp.org/afp/20001201/2433.html http://www.aafp.org/afp/20050115/315.html	*Direct Observation	Satisfactory Course Evaluation
Diagnosis and treatment of hematuria http://www.aafp.org/afp/20010315/1145.html	*Direct Observation	Satisfactory Course Evaluation
Diagnosis and treatment of Erectile Dysfunction http://www.aafp.org/afp/20000101/95.html http://www.auanet.org/guidelines/edmgmt.cfm	*Direct Observation	Satisfactory Course Evaluation
Diagnosis and treatment of ejaculatory dysfunction	*Direct Observation	Satisfactory Course Evaluation

http://www.auanet.org/guidelines/pe.cfm		
Prostate Cancer Screening Techniques and Standards http://www.cancernetwork.com/journals/oncology/o0002e.htm http://www.aafp.org/afp/980800ap/lefevre.html http://www.cancer.gov/cancertopics/pdq/screening/prostate/Patient/page3 http://www.ahrq.gov/clinic/uspstf/uspsprca.htm	*Direct Observation	Satisfactory Course Evaluation
Testicular torsion http://www.aafp.org/afp/20061115/1739.html	*Direct Observation	Satisfactory Course Evaluation
Male Infertility http://www.aafp.org/afp/20020615/practice.html http://www.auanet.org/guidelines/main_reports/optimalevaluation.pdf	*Direct Observation	Satisfactory Course Evaluation
Bladder Cancer http://www.auanet.org/guidelines/main_reports/bladdercancer.pdf	*Direct Observation	Satisfactory Course Evaluation
Priapism http://www.auanet.org/guidelines/priapism.cfm	*Direct Observation	Satisfactory Course Evaluation
Vesicouretral Reflux Management http://www.auanet.org/guidelines/main_reports/vesi_reflux.pdf	*Direct Observation	Satisfactory Course Evaluation
Interstitial Cystitis http://www.aafp.org/afp/20011001/1199.html	*Direct Observation	Satisfactory Course Evaluation
Groin Hernia http://www.aafp.org/afp/990101ap/143.html	*Direct Observation	Satisfactory Course Evaluation
testicular Cancer http://www.aafp.org/afp/990501ap/2539.html	*Direct Observation	Satisfactory Course Evaluation

ENT Specific Medical Knowledge Based Competency	**Measurement Tool**	**Expected Outcome**
Otitis externa diagnosis and management	Direct Observation	Satisfactory Course Evaluation

http://www.aafp.org/afp/20061101/1510.html		
Cerumen impaction, management of	Direct Observation	Satisfactory Course Evaluation
AOM, Serous Otitis Media http://www.aafp.org/afp/20040601/practice.html http://www.guideline.gov/algorithm/3727/NGC-3727.html http://www.guideline.gov/algorithm/3727/NGC-3727_1.html http://www.aafp.org/afp/20000401/2051.html	Direct Observation	Satisfactory Course Evaluation
Chronic Otitis Media	Direct Observation	Satisfactory Course Evaluation
Acute Sinusitis/,management of http://www.aafp.org/afp/20041101/1685.html http://www.aafp.org/afp/20041101/1697.html	Direct Observation	Satisfactory Course Evaluation
Chronic Sinusitis management of http://www.aafp.org/afp/20041101/1685.htmlhttp://www.aafp.org/afp/20041101/1697.html	Direct Observation	Satisfactory Course Evaluation
Epistaxis management http://www.aafp.org/afp/20050115/305.html	Direct Observation	Satisfactory Course Evaluation
Chronic cough management and work-up http://www.aafp.org/afp/20040501/2159.html http://www.aafp.org/afp/20030101/tips/10.html	Direct Observation	Satisfactory Course Evaluation
Chronic hoarseness management and work up http://www.aafp.org/afp/980600ap/rosen.html	Direct Observation	Satisfactory Course Evaluation
Cholesteatoma recognition and management		
Common Oral Lesions http://www.aafp.org/afp/20070215/501.html http://www.aafp.org/afp/20070215/509.html	Direct Observation	Satisfactory Course Evaluation
Oral Cancer recognition and work-up http://www.aafp.org/afp/20020401/1379.html	Direct Observation	
Otalgia Management		

Hearing loss diagnosis and management http://www.aafp.org/afp/20030915/1125.html	Direct Observation	Satisfactory Course Evaluation
Vertigo diagnosis and management (BP) http://www.aafp.org/afp/20060115/244.html http://www.aafp.org/afp/20050315/1115.html	Direct Observation	Satisfactory Course Evaluation
Acute Labyrinth		
Acoustic Neuroma/Schwannoma	Direct Observation	Satisfactory Course Evaluation
Tinnitus http://www.aafp.org/afp/20040101/120.html	Direct Observation	Satisfactory Course Evaluation
Eustachian tube dysfunction/diagnosis and management	Direct Observation	Satisfactory Course Evaluation
Allergic Rhinitis. Chronic and Seasonal diagnosis and management http://www.aafp.org/afp/20060501/1583.html	Direct Observation	Satisfactory Course Evaluation
Head and Neck Symptoms of GERD http://www.aafp.org/afp/990901ap/873.html	Direct Observation	Satisfactory Course Evaluation
Laryngitis	Direct Observation	Satisfactory Course Evaluation

Oral Health:

Complete "Smiles for Life Modules 1-7" PowerPoint Presentations

Attend Oral Health Clinic at Church Health

Ophthalmology Rotation Specific Medical Knowledge Goals:

Ophthalmology Specific Medical Knowledge Based Competency	Measurement Tool	Expected Outcome
Amblyopia http://www.aafp.org/afp/20070201/361.html	Direct Observation	Satisfactory Course Evaluation
Vision Screening Technique in children http://www.aafp.org/afp/980901ap/broderic.html	Direct Observation	Satisfactory Course Evaluation
Two Minute Eye Exam Video	Direct Observation	Satisfactory Course Evaluation

http://webeye.ophth.uiowa.edu/eyeforum/Two-Minute-Eye-exam.htm		
Strabismus		
Leukocoria		
The Red Eye http://taylorandfrancis.metapress.com/content/mdbwaxxjuyvn6e46/	Direct Observation	Satisfactory Course Evaluation
Glaucoma Primary Open Angle Secondary Open Angle Primary Angle Closure Secondary Angle Closure http://www.aafp.org/afp/990401ap/1871.html	Direct Observation	Satisfactory Course Evaluation
Nystagmus	Direct Observation	Satisfactory Course Evaluation
Management of non-penetrating trauma of orbit and lid	Direct Observation	Satisfactory Course Evaluation
Management of chemical burns http://www.emedicinehealth.com/chemical_eye_burns/article_em.htm	Direct Observation	Satisfactory Course Evaluation
Diagnosis and management of mechanical corneal abrasion http://www.aafp.org/afp/20040701/123.html	Direct Observation	Satisfactory Course Evaluation
Diagnosis and management of traumatic Hyphema	Direct Observation	Satisfactory Course Evaluation
Diagnosis and management of Bacterial and Viral Conjunctivitis http://www.aafp.org/afp/980215ap/morrow.html	Direct Observation	Satisfactory Course Evaluation
Diagnosis and management of Allergic Conjunctivitis http://www.aafp.org/afp/980215ap/morrow.html	Direct Observation	Satisfactory Course Evaluation
Diagnosis and management of Herpes Simplex and Zoster of the eye http://www.aafp.org/afp/20021101/1723.html	Direct Observation	Satisfactory Course Evaluation

Management of contact lens complications Contact Lens types http://www.allaboutvision.com/contacts/	Direct Observation	Satisfactory Course Evaluation
Diagnosis and management of Pterygium and Pinguecula	Direct Observation	Satisfactory Course Evaluation
Diagnosis and Management of Hordeolum and Chalazion http://www.aafp.org/afp/980600ap/carter.html	Direct Observation	Satisfactory Course Evaluation
Diagnosis and Management o Dacryostenosis and Dacryocystitis http://pediatrics.aappublications.org/cgi/reprint/76/2/172?maxtoshow=&HITS=10&hits&sortspec=relevance&resourcetype=HWCIT	Direct Observation	Satisfactory Course Evaluation
Diagnosis and Management of Blepharitis http://www.aafp.org/afp/980600ap/carter.html	Direct Observation	Satisfactory Course Evaluation
Diagnosis and Management of Orbital Cellulitis and Periorbital Cellulitis http://www.findarticles.com/p/articles/mi_m3225/is_6_67/ai_98626751	Direct Observation	Satisfactory Course Evaluation
Diagnosis and Management of Acute Visual Loss • Central Retinal Artery Occlusion • Central Retinal Vein Occlusion • Retinal Detachment • Posterior Vitreous Detachment • Vitreous Hemorrhage • Macular Disorders • Neuroophthalmologic Visual loss http://www.aafp.org/afp/20040401/1691.html	Direct Observation	Satisfactory Course Evaluation
Diagnosis and management of abnormal Extraoccular movements and pupil abnormality http://cim.ucdavis.edu/EyeRelease/Interface/TopFrame.htm	Direct Observation	Satisfactory Course Evaluation
Cataracts http://archopht.ama-assn.org/cgi/content/full/122/4/487	Direct Observation	Satisfactory Course Evaluation

Diabetic Retinopathy http://care.diabetesjournals.org/cgi/content/full/27/suppl_1/s84	Direct Observation	Satisfactory Course Evaluation
Causes of visual impairment http://archopht.ama-assn.org/cgi/content/full/122/4/477	Direct Observation	Satisfactory Course Evaluation
Iritis and ocular manifestations of Autoimmune Disease http://www.aafp.org/afp/20020915/991.html	Direct Observation	Satisfactory Course Evaluation
Eye disease video and web based tutorials http://webeye.ophth.uiowa.edu/eyeforum/tutorials.htm	Direct Observation	Satisfactory Course Evaluation

BMH/CH FM 2016 - 2017 Didactic Schedule

Didactic Days

1st and 3rd Thursday of every 4-week block
Journal Club will meet every 4th week
Resident Support Group will meet every 4th week

Date	Category		Date	Category
7/5/16	Professionalism		12/1/16	Preventive Medicine
7/6/16	Certification Course		12/1/16	Systems-Based Practice
7/8/16	Certification Course		12/1/16	Health Systems/ Population Health
7/11/16	Professionalism		12/2/16	Behavioral Health
7/13/16	Professionalism		12/2/16	Systems-Based Practice
7/14/16	Systems-based		12/5/16	Quality Improvement/ Patient Safety
7/18/16	Behavioral Health		12/5/16	Health Systems/ Population Health
7/18/16	Behavioral Health		12/7/16	Quality Improvement/ Patient Safety
7/18/16	Behavioral Health		12/7/16	Systems-Based Practice
7/18/16	Behavioral Health		12/7/16	Health Systems/ Population Health
7/18/16	Behavioral Health		12/8/16	Quality Improvement/ Patient Safety
7/20/16	Certification Course		12/9/16	Quality Improvement/ Patient Safety
7/21/16	Certification Course		12/9/16	Systems-Based Practice
7/22/16	Systems-Based Practice		12/9/16	Systems-Based Practice
7/26/16	Certification Course		12/12/16	Health Systems/ Population Health
7/27/16	Professionalism		12/12/16	Health Systems/ Population Health
7/27/16	Professionalism		12/14/16	Behavioral Health
7/27/16	Professionalism		12/14/16	Pediatrics
7/27/16	Support Group		12/14/16	Support Group
8/24/16	Gynecology		12/14/16	Behavioral Health
8/24/16	Behavioral Health		12/14/16	Health Systems/ Population Health
8/24/16	Internal Medicine		12/14/16	Quality Improvement/ Patient Safety
8/24/16	Support Group		12/15/16	Behavioral Health
8/24/16	Endocrinology		12/15/16	Preventive Medicine
9/21/16	Internal Medicine		12/16/16	Behavioral Health
9/21/16	Legal		12/16/16	Behavioral Health
9/21/16	Support Group		12/16/16	Health Systems/ Population Health
9/21/16	Quality Improvement/ Patient Safety		12/16/16	Health Systems/ Population Health
10/19/16	Emergency Medicine		1/5/17	Behavioral Health
10/19/16	Health Systems/ Population Health		1/6/17	Behavioral Health
10/19/16	Home Health		1/25/17	Behavioral Health
10/19/16	Support Group		1/25/17	Health Systems/ Population Health
10/19/16	Cardiology		2/8/17	Support Group
11/11/16	Support Group		2/8/17	Radiology
11/16/16	Palliative Care/ Hospice		2/8/17	Health Systems/ Population Health
11/16/16	Infectious Disease		2/8/17	Health Systems/ Population Health
11/16/16	Infectious Disease		2/22/17	Emergency Medicine
11/21/16	Health Systems/ Population Health		2/22/17	Critical Care
11/21/16	Health Systems/ Population Health		2/22/17	Neurology
11/23/16	Pediatrics		2/22/17	Surgery
11/23/16	Support Group		3/8/17	Orthopedics
11/23/16	Quality Improvement/ Patient Safety		3/8/17	Dermatology
11/28/16	Preventive Medicine		3/8/17	Emergency Medicine

11/28/16	Quality Improvement/ Patient Safety		3/8/17	Infectious Disease
11/30/16	Obstetrics		3/8/17	Support Group
11/30/16	Quality Improvement/ Patient Safety			
11/30/16	Health Systems/ Population Health			

BAPTIST MEMORIAL HOSPITAL – MEMPHIS

GRADUATE MEDICAL EDUCATION

PROGRAM POLICY AND PROCEDURE MANUAL

Effective Date: January 2016 Last Review/Revision: February 2016 Reference #: -	Annual Program Evaluation / Internal Review

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

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.

BAPTIST®

GRADUATE MEDICAL EDUCATION

Annual Program Evaluation / Internal Review

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 _____

TRAINEES	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5	PGY-6
Approved						
Filled						

Other Learners	Total # last 12 months	Maximum # at any time
Residents from other programs		
Medical students		
Subspecialty fellows		

Policies:

Do you have:	Yes	No
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):	Yes	No
1. Does the Program have a CCC?	☐	☐
2. Is the Program Director also the Chair of the CCC?	☐	☐
3. Has the CCC met to evaluate appropriate individual trainee progression?	☐	☐
4. Is the CCC comprised of faculty from all rotation sites and services?	☐	☐
5. Does the CCC provide feedback and mentorship to trainees?	☐	☐
6. Is the CCC satisfied with current 360* evaluation methods?	☐	☐
7. Do all CCC members participate in at least 50% of all discussions?	☐	☐
8. Does the CCC evaluate the Supervision Policy at least annually?	☐	☐
9. Does the CCC evaluate the trainee schedule at least annually?	☐	☐
10. Does the CCC evaluate the curriculum / goals & objectives at least annually?	☐	☐

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

- 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

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

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.

Participating Site	Date of PLA	In Compliance (Yes/No)

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 follow (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?	

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