Central Washington Family Medicine Residency Program
A Service of Community Health of Central Washington
1806 W. Lincoln, Yakima, WA 98902
(509) 452-4520

PGY-1 RESIDENT CONTRACT IN FAMILY MEDICINE

The Central Washington Family Medicine Residency Program (CWFMR), an accredited residency for training family physicians and sponsored by Community Health of Central Washington (CHCW) hereby enters into a contract of residency with **XXXX** subject to the following terms which supersede the terms of any previous contract or agreement.

AGREEMENT BY RESIDENCY:

The Central Washington Family Medicine Residency Program agrees:

1. To accept **XXXX** as a resident physician in Family Medicine for the period beginning XXXX and ending XXXX. Either party may terminate this contract by providing the other party with 30-days written notice.

2. To maintain an approved Family Medicine residency program in keeping with the standards established by the Accreditation Council for Graduate Medical Education (ACGME), the Residency Review Committee for Family Medicine (RC), the American Board of Family Medicine (ABFM), and the American College of Osteopathic Family Physicians (ACOFP). CWFM-R has received the ACGME Osteopathic Recognition accreditation.

3. To ensure provision of sufficient financial support for administrative, educational, human and clinical resources, to ensure excellent family medicine graduate medical education, in collaboration with the CWFMR's sponsoring institution CHCW.

4. To comply with the guidelines of the ACGME with regard to resident workload and Clinical and Educational work hours (formerly known as duty hours).

5. To provide twenty (20) days of paid Time Off (PTO) per year that may be used as provided in the Resident PTO Policy found in Resident Handbook and the CHCW HealthStream Document Library. Residents will submit requests for 10 days of PTO (in 5 day increments) in May; of the remaining 10 days, 5 days will be held until the last 90 days of the academic year, and 5 days can be requested 90 days in advance. Unused PTO, up to 40 hours, will be paid out at the end of the academic year.

6. To provide up to $1,500 in professional development funds to be used during the PGY-1 through the PGY-3 years in accordance with professional development policies. Unused professional development funds are not paid to the resident.

7. To provide timely notice of the effects of leave(s) of absence on the ability of the resident to satisfy requirements for program completion, including possible required training extensions.

8. To extend the date of completion of (PGY Year) training in accordance with the American Board of Family Medicine and the American College of Osteopathic Family Physicians continuity requirements for leaves of absence from the residency in excess of Paid Time Off (PTO) granted in each year of training, and in accordance with the Institutional GME PTO

Policy. Extended personal leave is granted at the discretion of the Program Director for compelling personal reasons.

9. To ensure information related to eligibility for Family Medicine board examinations is communicated to the resident, particularly when specific requirements are not met and would impact the resident's ability to sit for Family Medicine board exam(s).

10. To provide six weeks approved medical, parental, and caregiver leave (s), available the first day of residency, and paid at 100% salary, as outlined in the Institutional Paid Time Off Policy in Attachment A.

11. To assure that the participating hospitals furnish meals and sleep rooms when the resident is on call in their institutions.

12. To provide health insurance (Medical, Dental, Vision) according to the current CHCW Plan(s) for residents and their eligible dependents. Coverage begins that first day of the month following the contract start date. Residents wishing to purchase interim coverage can do so through the Washington Health Plan Finder at https://www.wahealthplanfinder.org/ Residents and their eligible dependents currently have the option of 3 health insurance plans:

    A. The Preferred Provider Premium Plan in which the resident pays a portion of the premium for the resident and 50% of the premium for dependents.
    B. The CHCW High Deductible Plan and Health Savings Account (HSA) in which CHCW pays the premium for the resident, 50% of the premium for dependents, and makes and annual contribution to an HSA. The resident is responsible for the premiums for dependents, co-payments, and deductibles.
    C. The CHCW High Deductible Value Health Plan in which CHCW pays the premium for the resident, 50% of the premium for dependents, and makes and annual contribution to an HSA. The resident is responsible for the premiums for dependents, co-payments, and deductibles.

13. To pay the State of Washington physician license fees (MD/DO) and the Drug Enforcement Administration registration fees.

14. To provide Professional Liability Insurance that applies to any professional acts performed by residents within the approved CWFMR educational program. Liability insurance is provided by CHCW through the Federal Torte Claims Act for any professional acts within a resident's scope of employment. In the event there are gaps in coverage, CHCW provides gap insurance through Physician's Insurance.

15. To pay necessary dues and assessments for the American Academy of Family Physicians, the Washington Academy of Family Physicians, the American College of Osteopathic Family Physicians, the Washington Osteopathic Medical Association, and the Yakima County Medical Society.

16. To provide disability insurance for residents at the expense of CWFMR.

17. To provide confidential counseling and behavioral health services, via an Employee Assistance Program for the use of the resident and their family.

18. To pay taxes for Workmen's Compensation and Unemployment on behalf of the resident, and to deduct Social Security from the resident's salary, and match the deduction.

19. A Certificate of Advancement will be issued upon satisfactory completion of all program requirements for the (PGY Year) level of training.

20. To follow the process as described by the grievance procedure detailed in the Grievance Policy and Education Advancement Committee Policies shown in attachments B and C.

DUTIES OF THE RESIDENT:

I, **XXXX**, agree:

1. To withdraw from the NRMP match systems, if applicable.

2. To be fully vaccinated according to CHCW policy with the following vaccinations:

    a. 2 doses of MMR vaccine (titers will be accepted if proof of vaccination is not available)
    b. 2 doses of Varicella vaccine (titers will be accepted if proof of vaccination is not available)
    c. 3 doses of Hepatitis B vaccine (titers will be accepted if proof of vaccination is not available)
    d. Tdap vaccine within the last 10 years
    e. Current annual influenza vaccine

3. Show proof of negative tuberculosis infection with a negative QuantiFERON-TB Gold blood test or show proof of previous completed tuberculosis treatments.

4. To fulfill the duties of a Family Medicine resident during the entire period agreed upon as specified in this contract. I agree to participate in all areas of that curriculum. This may include additional assignments in areas of medicine deemed necessary or appropriate by the faculty for completeness of experience and education in Family Medicine. By signing this agreement, you accept and acknowledge that you will be trained and expected to become proficient in at least the following: physical exams (male and female/transgender) including foot, breast, genitourinary and rectal exams; educating patients about and prescribing birth control; educating and administering vaccinations for all ages-including Covid; providing care regardless of race/ethnicity, religion, gender identity, socioeconomic status and culture.

5. To read and observe all policies, rules and regulations of this residency and the sponsoring and participating institutions; and to consider that any infraction thereof will be full justification for discipline up to and including dismissal from the program.

6. To read and abide by CHCW and Residency policies and procedures regarding resident clinical and educational work hours and moonlighting as outlined in the Institutional Educational Work Hour Policy shown in Attachment D.

7. To complete required items necessary for a resident to remain eligible for Family Medicine board examination requirements.

8. To consider the salary, as well as the experience and instruction received, as sole compensation, and not to engage in any employment outside the auspices of CWFMR. Exceptions for Moonlighting in the PGY3 year are subject to approval by the Program Director, as outlined in the Residency Program Moonlighting Policy shown in Attachment E.

9. To assume responsibility for all acts performed outside the course and scope of the training provided by CWFMR, and to indemnify and hold harmless CWFMR regarding such acts.

10. To participate in educational duties and conferences, including required and elective hospital, non-hospital and community-based rotations and didactics, and to meet the training requirements of the residency as defined by the approved curriculum.

11. To obtain and maintain licensure in accordance with the laws of the State of Washington while a member of this residency. If I do not obtain such license for any reason whatsoever, this contract is automatically canceled.

12. To charge fees as established and agreed to by Community Health of Central Washington and to agree that all fees that are obtained from such services shall be the property of Community Health of Central Washington, free from any claim or interest by me.

13. To abide by the by-laws, rules, and regulations of the sponsoring and participating institutions of this residency. Suspension from any hospital for delinquent records or for any other reason may result in disciplinary action.

14. To have reliable transportation for travel to and from the hospitals, the clinic, and assigned rotation sites.

ESSENTIAL FUNCTIONS:

The PGY-1 Job Description shown in Attachment F includes abilities that are representative of those required of a resident in Family Medicine at CWFMR. The list is not meant to be all-inclusive, nor does it constitute all academic performance measures or graduation standards. It does not prevent the residency from temporarily restructuring resident duties as it deems appropriate for residents with acute illness, injury, or other circumstances of a temporary nature.

REAPPOINTMENT AND PROMOTION:

Advancement to the next PGY year, or completion of the program, is contingent upon successful completion of all required PGY rotations, and assignments, and the program's goals and objectives in the core competencies. These are defined by the ACGME Family Medicine Specialty Milestones. Resident are evaluated by faculty members, and all evaluations are reviewed semi-annually by the Clinical Competency Committee (CCC). The CCC then reports their recommendations for promotion and/or higher levels of responsibility to the Program Director.

MISCELLANEOUS PROVISIONS

1. Amendment. This Agreement may be amended or modified only by a written document signed by both parties hereto.

2. Entire Agreement. This Agreement constitutes the entire agreement between CWFMR and Resident with respect to matters relating to Resident's employment, and it supersedes all previous oral or written communications, representations, or agreements between the parties.

3. Partial Invalidity. If any provision in this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will nevertheless continue in full force without being impaired or invalidated in any way.

4. Governing Law. This Agreement will be governed by and construed in accordance with the laws of the State of Washington.

TERM AND SALARY:

This agreement for the PGY-1 year is for the period from XXXX and ending XXXX. Annual salary for this year of residency is XXXX. Contract end dates are at the discretion of the Program Director and based upon ACGME and ABFM required clinic continuity numbers, patient encounter totals and/or any other factors affecting extension of residency status including Probation.

_____ _____

Date **XXXX**
Resident Physician

_____ _____

Date **XXXX**
Program Director

Attachment A

Institutional GME Paid Time Off (PTO) Policy
Community Health of Central Washington

Approved By: CEO **Effective Date: 8/17//2023**
Supersedes: 6/2022

Purpose:
The purpose of this policy is to address all relevant leave provisions and policies regarding Resident leave of absence, as required by the ACGME and in accordance with state law, federal law, and CHCW Policies. Paid time off (PTO) and leaves of absence are a benefit designed to provide residents/fellows with the flexibility to use time off to meet personal needs. PTO may be used for vacation, illness, caring for family, school activities, medical/dental appointments, leave, personal business, holidays not recognized by Community Health of Central Washington (CHCW) or emergencies. PTO may be used at the resident's discretion and subject to the scheduling needs of CWFM and CHCW-Ellensburg.

Background:
Training programs and Residents must comply with the following policies and guidelines affecting Residents' leave:

1. Family and Medical Leave Act (FMLA) – Federal law which provides job protection and benefit continuation.
2. Washington Paid Family and Medical Leave (PFML) – Paid leave and job protection program administered by the State of Washington.
3. Disability Leave - A leave of absence that may be granted to an employee that is unable to perform the essential functions of their position, with or without reasonable accommodation, because of their own medical condition.
4. Specialty Board requirements – Restrictions on the amount of time away from training before a training extension is required.
5. ACGME Institutional Requirements –
   To comply with ACGME Institutional Requirement that state Community Health of Central Washington (CHCW) must have a policy for vacation and leaves of absence, consistent with applicable laws. This policy must: [IR - IV.H.1.]
   Provide residents/fellows with a minimum of six weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, starting the day the resident/fellow is required to report; [IR - IV.H.1.a)]

   Provide residents/fellows with at least the equivalent of 100 percent of their salary for the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken; [IR- IV.H.1.b)]

   Provide residents/fellows with a minimum of one week of paid time off reserved for use outside of the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken; [IR -IV.H.1.c)]

   Ensure the continuation of health and disability insurance benefits for residents/fellows and their eligible dependents during any approved medical, parental, or caregiver leave(s) of absence; [IR -IV.H.1.d)]

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Describe the process for submitting and approving requests for leaves of absence; [IR IV.H.1.e)] Policy must be available for review by residents/fellows at all times; [IR-IV.H.1.f)]

Ensure that each of its ACGME-accredited programs provides its residents/fellows with accurate information regarding the impact ofan extended leave of absence upon the criteria for satisfactory completion of the program and upon a resident's/fellow's eligibility to participate in examinations by the relevant certifying board(s). [IR-IV.H.1.g]

GMEC responsibilities must include: [IR - I.B.4.] Oversight of: [I.B.4.a)] ACGME-accredited programs' implementation of institutional policy(ies) for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence, at least annually [IR I.B.4.a).(5]

Policy

Paid Time Off (PTO) Usage/ Leave:

1. CHCW Resident Physicians will be given 20 days of Paid Time Off (PTO) each academic year. PTO will be available and may be used immediately per the guidelines below.
2. Programs have discretion to determine how and when vacation must be taken. This must be outlined in the program's leave policy. Programs may require residents to take vacation in full-week increments, and it may not be scheduled during inpatient rotation, and other program specific rotations, as outlined in programs' specific Paid Time Off Policy.
3. No more than 5 consecutive days off may be taken during any rotation. Exceptions will be approved only if the activity is required by the residency program. Consecutive days can include weekends/holidays, weekends do not count toward PTO. Exceptions will be granted in cases of acute illness, emergency, or otherwise approved activities.
4. Programs will make every effort to grant PTO requests. The earlier a request is received; the more likely adjustments can be made for adequate staffing. There are no guarantees that PTO requests can be accommodated and will be approved. There are no guarantees that PTO requests can be accommodated and will be approved.
5. Paid holidays recognized by CHCW that fall within a PTO request period will be counted as Holiday Pay and not decrease the PTO balance.
6. Paid Time Off must be utilized before a request for unpaid leave of absence will be considered.
7. PTO and leave benefits are available to residents after the first full day of employment at the Community Health of Central Washington. Residents receive their full paid time off balance at the beginning of each appointment period.
8. Residents can use vacation, sick, and/or paid personal holiday paid time off balances to remain in paid status during an approved leave of absence. Otherwise, the leave is unpaid.
9. Residents must apply for FMLA or PFML to guarantee the continuation of health and disability insurance benefits.

10. If a Resident is seeking to use or has used sick time off for authorized purposes for more than three (3) consecutive days the employer may require a Resident to provide verification that establishes that the use of sick time off is for an authorized purpose.
    a. Verification must be provided within 10 calendar days of the first day of used sick time off to care for yourself or a family member.
    b. The Resident is not required to provide any details concerning the specific nature of the health condition in order to use sick time off, unless otherwise required by law.
11. In accordance with ACGME Institutional Requirements, Residents must have enough paid time off available to remain in 100 percent paid status for the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken.
12. Residents may use vacation, sick, paid personal holiday, and/or PFML to remain in paid status.
13. If a resident does not have enough PTO to remain fully paid for at least six weeks of the first LOA, additional PTO will be allocated to remain in compliance with ACGME's requirement.
14. Additionally, if a resident uses up all their PTO as part of their first LOA. An additional week of PTO will be provided to be used within that same academic year. This additional week does not rollover.
15. Programs have discretion to determine how and when vacation must be taken. This must be outlined in the program's leave policy. A. Programs may require Residents to take vacation in full-week increments

<u>Unused PTO Balance</u>:

1. At the end of each academic year, Residents are eligible to cash out up to 40 hours of unused PTO. The cash out amount is calculated based upon the hourly rate during the year the PTO was given. PTO cash out dollars are added to the next applicable paycheck and will be subject to the usual income tax. PGY-1 and PGY-2 residents are required to submit the applicable HR form, PGY-3 unused PTO will be automatically added to final paychecks. See Resident PTO Cash Out Procedure for more information.
2. If a Resident's appointment is extended due to an approved leave of absence, the Resident's current appointment level will be extended until the training requirements of the original appointment period are completed, if the resident continues to progress through the training program. The Resident will continue to receive the compensation level applicable to their current appointment level during the extension.
3. Changes to the compensation schedule specific to the current academic year will apply.
4. If the training year extends beyond the normal duration of twelve (12) months for reasons other than a leave of absence, additional sick and vacation paid time off benefits will be provided on a prorated basis for the duration of time the Resident is in pay status during the extension of training.
5. Approved leaves of absence without pay should not exceed twelve (12) months in duration.

a. Requests for leave extensions beyond the twelve (12) month limitation must be approved by the GME Office.
b. Extended military service leaves are an exception to this requirement.

Procedure:

1. Program Responsibilities
    a. Programs must have a clear leave policy that outlines the leave and paid time off request process. The policy must provide residents with documented guidelines regarding how to request leave from the program.
    b. Processes for initiating leave requests, including timelines, may vary by program.
    c. The policy must state any restrictions or limitations on paid time off usage for specific rotations, time of the year, or other circumstances at the start of each academic year.
    d. This policy must be made available to Residents and shared at least annually. Programs must notify the GME Office when a resident takes a leave of absence prior to PFML eligibility (e.g. when a LOA is requested within the first five months of a training program) to ensure compliance with ACGME vacation and leave requirements.
    e. Residents must be provided with an appropriate leave of absence without fear of negative consequences. If a Resident takes any unpaid leave during the program (e.g., during an extended leave of absence, unpaid Personal Holiday), the Program Administrator is responsible for notifying the department HR/payroll staff of the number of Unpaid Time Off days to be entered in Workday. It is the responsibility of the Program Director to assure that appropriate coverage of patient care by colleague residents and/or faculty of the respective departments is provided as required during the Resident's leave of absence.

2. Resident Responsibilities
    a. Residents are responsible for communicating and obtaining approval for planned paid time off from their program, in accordance with program policy.
    b. All leave and paid time off must be reported to the program, including while residents are on non-clinical rotations or research rotations.
    c. Residents must request all leave and paid time off time in advance of the desired dates, apart from any unforeseen situations (e.g., sick leave), in accordance with program policy.
    d. Residents are encouraged to communicate planned medical and/or parental leave as soon as possible in advance of the estimated start date for the absence.
        a. Note that the program cannot require residents to communicate planned medical leave.
    e. The timeline for broader communication to impacted services should be mutually agreed upon between the Resident and program.
    f. Residents may request Academic Year-to-Date reports on paid time off used at any time from their Program Administrator.

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Approved By: CEO **Effective Date: 8/17//2023**
Supersedes: 6/2022

3. Covid Procedure: Residents should contact Stacy Martin (Stacy.Martin@chcw.org) in Employee Health if Covid is suspected or the resident meets criteria for having been exposed. If a Resident is unable to work, they must enter two days of PTO into CHCW timekeeping (UKG) then they may Self Study until released to return to work by Employee Health. If a Resident is too ill to work then they must take PTO and enter it into CHCW timekeeping (UKG).

Forms:
Resident PTO Cash Out Form

Related Policy:
CHCW PTO Policy

Angela Gonzalez
Angela Gonzalez (Aug 17, 2023 15:18 PDT)

Angela Gonzalez, Chief Executive Officer
Community Health of Central Washington

08/17/2023
Date

Attachment B

CWFM Residency Program Grievance Policy and Procedure

Approved By: Program Director
Supersedes: **Effective Date: 7/2023**

Purpose: *To comply with both ACGME Institutional and Family Medicine Program Requirements that require processes to support the raising of resident concerns, and a process for addressing resident grievances.*

Policy: There must be both institutional and programmatic processes/policies that support residents in raising concerns and providing feedback confidentially and that determine the criteria for promotion and/or renewal of resident appointments. If attempts to address concerns within the program fail, residents must be able to raise concerns or provide feedback confidentially through institutional mechanisms (ACGME Institutional Requirements (IR) III.A and IV.D), which may include specific, confidential reporting processes related to patient safety events, supervision concerns, or professionalism issues. The Sponsoring Institution must have a policy that outlines the procedures for submitting and processing resident/fellow grievances at the program and institutional level and that minimizes conflicts of interest.(IR IV.E)
Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns (CPR VI.B.4, VI.B.5 and VI.B.6).

***Procedure for resident reporting of concerns or feedback*:**

1. The Sponsoring Institution-Community Health of Central Washington (CHCW) with more than one program must ensure availability of an organization, council town hall, or other platform that allows all program learners from within and across the Sponsoring Institution's ACGME.
2. The Resident Concern Workflow shown in Figure 1 outlines the actions that should be taken by residents for reporting and addressing concerns related to the program, clinic, hospital, and curriculum/rotations, as well as how to address concerns regarding other residents, faculty, or residency leadership.
3. Residents can confidentially report patient safety and programmatic concerns and feedback using the Sponsoring Institution's-Community Health of Central Washington's (CHCW) Event Management System. The Event Management System also allows for anonymous submittal. The link to access the Event Management System is found on the CHCW Intranet.
4. Residents and Faculty are monitored for ACGME Annual Survey completion and meetings are held with residents/faculty to discuss the outcomes.
5. CWMFR conducts an Annual Program Review each May, Attendees include residents, faculty, administrators and ancillary providers who together review each rotation and provide feedback.

CWFM Residency Program Grievance Policy and Procedure

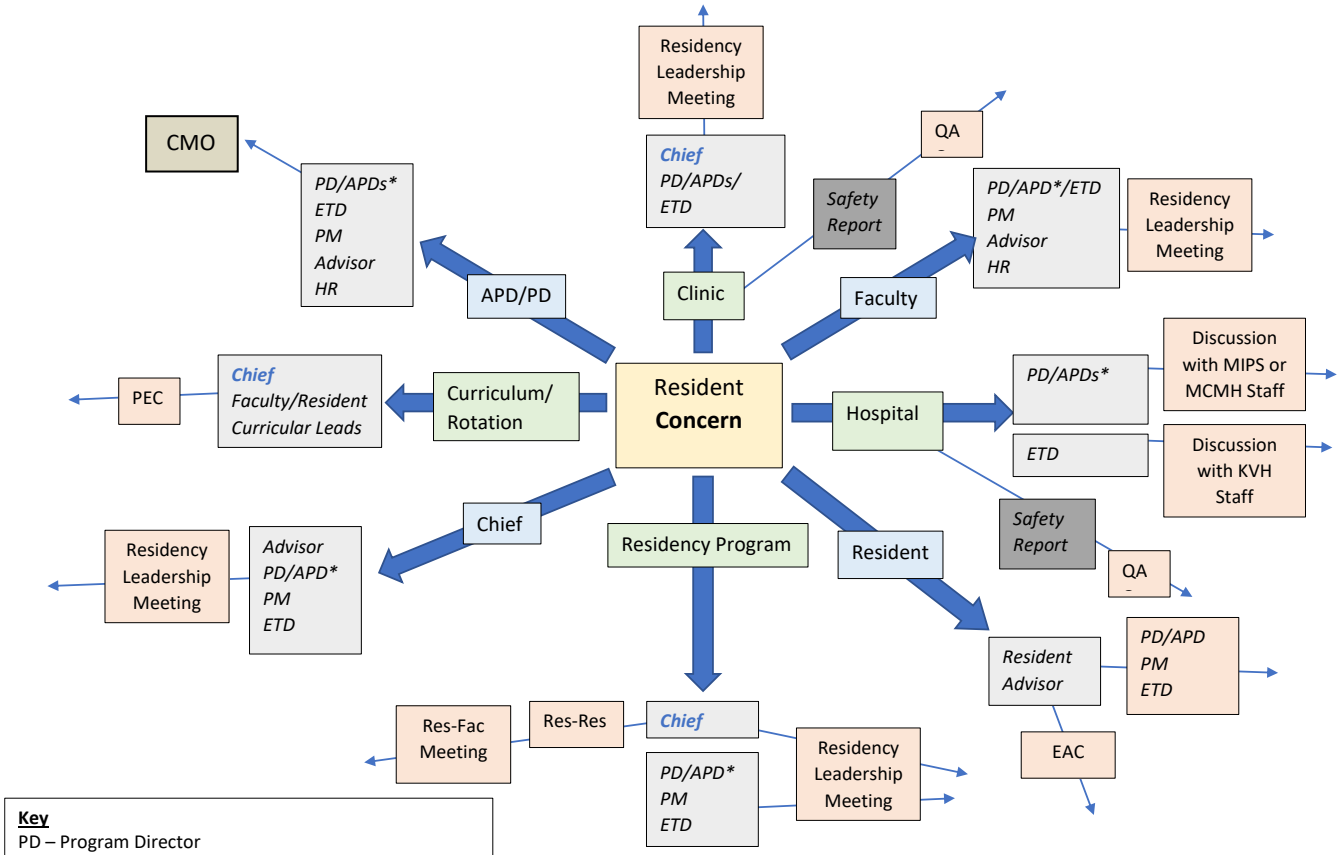
Approved By: Program Director
Supersedes: **Effective Date: 7/2023**

Procedure for resident grievance:

1. All residents are reviewed quarterly and presented by the resident's advisor to the full faculty. Presented metrics include: ITE scores, clinic production, ABFM CSK/KSAs, evaluation input from rotation and clinical evaluations, and formative comments. Feedback is solicited from all faculty present.
2. Advisors meet quarterly with their advisees to discuss the results of Quarterly Evaluations. Residents can voice concerns to their advisors.
3. Significant deficiencies or concerns about resident achievement are addressed by the Educational Advancement Committee (EAC) to determine further evaluation, actions or remediation.
4. Constructive Citations are noted for areas of concern on which the resident should focus his/her study but are not serious enough to cause concern about advancement.
5. Consequential Citations are issued for areas of concern significant enough to require the resident and faculty to develop a formal plan of corrective action.
6. Failure to correct these areas within a specified time frame may result in remediation and probation.
7. Elective time may be used for required remediation, but no more than four weeks of elective time may be used for remediation in any year of the academic program.
8. If the resident fails a rotation or does not correct a Consequential Citation within the specified time, he/she is placed on a Probation Citation with expectations and timeline for re-evaluation determined.
9. The period of training may be extended for the resident placed on Probation to meet the completion of training requirements. The Program Director is responsible for determining a resident's ability to practice autonomously.
10. The intention to terminate training may be initiated by the resident or the DIO/PD with a 30-day written notice.
11. If the resident does not agree with the DIO/PD's decision to terminate training, the resident may submit a grievance in writing to the DIO/PD within five (5) days to ensure that due process was followed.
12. If the resident is not satisfied with the DIO/PD's regarding response regarding due process, the resident may submit a written request for review of the process to the CHCW Executive Leadership within five (5) days.
13. The CEO's decision will be final and binding.

CWFM Residency Program Grievance Policy and Procedure

Approved By: Program Director
Supersedes: **Effective Date: 7/2023**



Key
PD – Program Director
APD – Associate Program Directors
ETD – Ellensburg Rural Track Director
PM – Residency Program Manager
HR – Human Resources
EAC – Educational Advancement Committee
PEC – Program Evaluation Committee
*Discussion with APDs can be impromptu via email, face-to-face etc. or through scheduled IGNITE Rounding Sessions

Attachment C

CWFM Residency Education and Advancement Committee (EAC)

Approved By: Program Director
Supersedes: 2/1/2021 **Effective Date: 7/2023**

Purpose
ACGME requires programs, in partnership with their Sponsoring Institutions, to document processes for educating residents and faculty regarding unprofessional behavior and the confidential process for reporting, investigating, and addressing such concerns (CPR VI.B.6)

Mission
The Central Washington Family Medicine Residency Program (CWFMR) is a funded Teaching Health Center. The program's institutional sponsor is Community Health of Central Washington (CHCW), a federally qualified health center (FQHC), whose mission is **to provide quality health care through service and education**. To this end, the residency program is committed to providing residents with the tools they need to become successful practicing family physicians that receive certification from the American Board of Family Medicine and/or the American Osteopathic Board of Family Physicians.

An essential component of assessing resident progress is through the Accreditation Council for Graduate Medical Education (ACGME) milestone attainment. While residents meet various milestones at different stages of training, residents are ultimately at differing levels of achievement during their training. Some may even require remediation. Ultimately the review and remediation process is designed to ensure residents meet their gates and overcome deficits in ACGME core competencies to attain all ACGME Entrustable Professional Activities (EPAs) required for Family Medicine Physicians at the time of graduation.

This committee aims to provide systematic review of every resident as they work toward meeting their professional goals. The committee will use metrics (ITE results, Milestone data, Evaluations, CSK completion, patient numbers etc.) as well as information reported to the residency program from both internal and external stakeholders about personal and professional issues that occur in order to develop personalized learning and improvement plans or corrective actions needed to ensure resident success. The overarching goal of this committee is to proactively ensure residents meet accreditation goals. The committee seeks also to identify areas of needed growth before they become problematic and to prevent, and/or avoid continuance of challenges faced by each resident by implementing strategies to overcome those challenges.

Due Process

1. **Committee Structure**

    a. **Membership**: As assigned by the Program Director (PD): Program Manager and/or Residency Site Coordinator, Medical Educator, Human Resource Director, Behavioral Health Education Director, Chief Experience Officer, Faculty member, and the PD, (the rotating clinical faculty member will not be assigned advisees during their tenure with the committee). A quorum will be attained if 4 of the members are present in person or on the

phone. Additional participation may include other physician or behavioral health faculty as assigned by the Program Director.

(1) Site-Based Participation: Committee members contributing to the quorum will be asked to participate based on congruency between their home site and the home site of the resident. For example, if the resident is an Ellensburg resident, Ellensburg faculty will be preferentially asked to participate to best contribute to resident site-specific oversight depending on the location needs.

b. Permanent members:
Program Manager (Chair)
Program Director (PD)
Medical Educator
HR Director
BHC Education Director
Rotating Clinical Faculty Member
Chief Experience Officer (CXO)

c. **Rotating members**: Physician faculty member

d. **Meetings** may be scheduled outside normal scheduled review meetings depending upon the urgency of the intervention required. The expectation is that committee members will make themselves available either by phone or in person to achieve quorum.

e. Site-Based Participation: Faculty, staff and coordinators will be involved based on home site of resident in difficulty and relevance to the individual resident.

f. **Optional Contributors:** Residents will be given the option to have a Chief Resident and/or their advisor represent them during committee evaluation however, the Chief Resident will not be involved in disciplinary action decision making if required.

(1) Exceptions: Per above if the advisor feels they do not have the experience and/or resources to address a given area of concern, the steps to informal remediation will be addressed by the committee in conjunction with the resident advisor.

g. **Remediation:** If remediation is required the following different intervention levels may be implemented based on recommendations from the committee and approved by the PD:

1. **Formal Referral Follow-Up**: Following a referral, the Program Manager contacts involved parties to acquire additional information. They will then review the situation with

additional parties to collect data relevant to the deficiency/area of concern (i.e. advisor, nursing, etc.). The Program Manager will then provide committee members and the resident's advisor with a brief outline (via email) of the circumstances and possible recommendations, asking for input from the committee and advisor. After review of comments and suggestions, the committee chair summarizes the feedback and schedules a meeting for follow-up as deemed necessary (see below). Major problems requiring formal remediation (e.g. issues regarding patient safety and/or ethical lapses) or recurrent problems will result in formal referral. The resident advisor may request assistance for issues requiring informal remediation if they feel they do not have the experience and/or resources to properly address the issue being addressed.

2. **No Action Necessary**: No remediation is determined as necessary at the current time. Note, the referral to committee and determination of "no action necessary" will be kept on file for program tracking and liability purposes. This is the most likely scenario during periodic review.

3. **Committee Referral**: Residents will be reviewed by the committee by any one of the following sources: Circumstances may occur where any individual who supervises or works collaboratively with a resident, including: faculty members, nursing supervisor or lead RN, Chief Resident/s, clinic manager, the resident in difficulty, and the CCC may request additional review.
    a. All referrals should be sent via an email addressed to the Program Manager and
    advisor (as applicable), copying the Program Director, unless issues are discovered during formal review processes such as quarterly reviews, faculty meeting or CCC committee meeting, etc.

b. Issues Requiring Formal Remediation: The following list is representative of the types of activities which may result in formal remediation per the resident handbook. Since there is no way to identify every possible violation of standards of conduct, including harassment or discrimination, the list is not intended to be comprehensive and does not alter the employment-at-will relationship between the resident and the program.

1. Falsifying or omitting of information in the Resident's application or personnel information.
2. Unauthorized possession or use of CHCW materials, time, equipment or property.
3. Gambling, violating criminal law, carrying weapons or explosives on Community Health of Central Washington premises.
4. Fighting, throwing things, horseplay, practical jokes or other disorderly conduct which may endanger the well-being of any Resident, employee, patient or visitor.

5. Engaging in acts of dishonesty, fraud, theft or sabotage.
6. Threatening, intimidating, coercing, using abusive or vulgar language, or interfering with the performance of other Residents or employees.
7. Insubordination or refusal to comply with instructions or failure to perform reasonable duties as assigned.
8. Damaging or destroying program property due to careless or willful acts.
9. Negligence in observing fire prevention and safety rules.
10. Irregular attendance or absence without notice.
11. Conduct that adversely reflects on the Resident or Community Health of Central Washington.
12. Work performance that does not meet the requirements of the position.
13. Engaging in practices inconsistent with the ordinary and reasonable rules of conduct necessary for the welfare of Community Health of Central Washington, its employees, patients, or visitors.
14. Any acts, conduct or omission deemed of a serious nature by Community Health of Central Washington.
15. Residents who have 30 delinquent charts, greater than 30 days and have received 3 warnings.

c. Formal Remediation Documentation: Formal remediation is required if there is considered a problem that is significant enough to warrant immediate intervention (e.g. patient safety concerns; see list above) or a chronic deficiency that has not been corrected (e.g. late charting) (Smith *et al*., 2017). Once referred to the committee for formal remediation, the committee will supply the resident, advisor and the program director with the following:

1. Written documentation of the problem containing data from all parties involved.
2. Documentation of any prior attempts by the program to help the resident remediate the deficiency or deficiencies.
3. Steps that the resident needs to complete to address the problem (i.e. learning plan).
4. Description of further steps to be implemented if resident **fails** to improve; this will include a required timeline for follow-up and improvement.

d. Remediation Levels:

i. **Informal:** Informal remediation represents the first step in the process if required and is initiated when warning signs of challenges exist, but they are not so significant to warrant immediate formal remediation (Smith et al., 2017). Therefore, these are primarily addressed by the resident and their advisor, other faculty, or the Program Director. It may

be determined the resident should require a plan of intervention. This plan is submitted by committee to the program office. The advisor and resident are expected to follow-up and report progress to the committee as outlined in their individual improvement plan. Examples of informal remediation action plans include: apologizing to offended party, not leaving clinic until charting is complete, referral to outside evaluations, etc

ii. **Formal Remediation—Constructive Citation:** Constructive Citations are areas of concern on which the resident should focus his/her study but are not serious enough to cause concern about advancement. These citations should receive at least **quarterly** follow-up by a clearly delineated person and process outlined in the formal remediation plan. Once the committee has convened, the resident and their advisor will be responsible for implementing a formal action plan. If the resident has not achieved goals by the time specified in their remediation plan, they will escalate to a Level 2 remediation (*Consequential Citation*).

iii. **Formal Remediation—Consequential Citation:** Consequential Citations are areas of concern significant enough to require the resident and faculty to develop a formal plan of corrective action. Failure to correct these areas within a specified time frame will result in required additional remediation and possible probation. Elective time is used for required remediation, but no more than four weeks of elective time may be used for remediation in any year of the academic program. These citations must receive **monthly** follow-up by any of the committee, program director, or advisor in person or by email.

iv. **Formal Remediation—Probation:** The committee may recommend a resident for probation to the PD. The committee and PD should reach consensus in the decision to put a resident on probation. Lack of consensus on probation will result in additional reviews between the committee and the PD. Documentation of the probation plan is signed by the resident, faculty advisor and PD and placed in the resident file. This signed document is copied and given to the resident. The resident will then work closely with their advisor and the committee to overcome deficits contributing to probation. Probation should receive **at least monthly** follow-up with the committee **and/or,** advisor in person or by email.

v. ****It is important for all parties to recognize that imposition of a probation period is reportable in the summative final evaluation of the PD and is reportable on licensing and credentialing documents.*

vi. **Formal Remediation—Suspension:** If an identified resident is deemed not safe to continue the practice of family medicine and/or the program needs additional time to review a serious problem, a temporary suspension from clinical duties is an option for the

program. The steps needed to suspend a resident are the same as Probation (see above). If the committee considers the resident unsafe to practice medicine and has failed remediation, then dismissal rather than remediation is recommended.

vii. ****It is important for all parties to recognize that imposition of a suspension/probation period is reportable in the summative final evaluation of the PD and is reportable on licensing and credentialing documents. In addition, it will add to the length of training.*

a. Notice of Suspension must contain the following:
1. Documentation of any prior attempts by the program to help the resident remediate the deficiency.
2. Steps that the resident needs to complete to address the problem.
3. Description of how the program will evaluate progress in resident's response to the problem.
4. Description of further steps that could be implemented if the resident fails to improve; including termination.
5. Documentation of the suspension will be signed by the resident, faculty advisor, and PD and placed in the resident's file. This signed document is then copied and given to the resident.

e. Formal Remediation—Dismissal: Dismissal is considered a final decision with permanent severing of the education and financial contract with the resident. Dismissal will only follow failure to meet agreed upon goals/expectations while on probation. Dismissal can be considered as an initial step if the deficiency in ACGME competency was so egregious as to represent an immediate step to protect the public from the continued practice of medicine by the given resident.

1. A resident must be able to have credentials at the training institutions where patients are seen: Virginia Mason Memorial Hospital; R; Kittitas Valley Healthcare. A resident also must also maintain their credentials at Community Health of Central Washington. Any action that terminates their privileges or their credentials can result in dismissal from the residency.

2. The steps that must be taken to dismiss a resident are the same as those listed for probation above. Upon dismissal, further follow up with the resident should be via Human Resources.

f. Non-renewal of contract: The committee may recommend a resident's contract not be renewed for the following academic year. In this case, the resident completes the current year

of training, but is not offered a contract for the ensuing year of training. The final decision not to renew a contract is made by the PD. This step can be considered when steps to remediate a competency issue(s) are unsuccessful. Notification of non-renewal should occur at least 90 days before the end of the resident's academic year. Decision is to be based on the same criteria as used for dismissal.

g. Grievance Procedure: If the resident does not agree with the Program Director/committee's decision (including dismissal), the resident may submit a grievance in writing to the Program Director/committee within five (5) business days. If satisfactory resolution is not reached, the resident may within five (5) business days submit a written request for review of the due process to the CHCW Chief Executive Officer (CEO). The CEO's decision will be final and binding. Please refer to the detailed Grievance and Due Process Policy (http://pandp.chcw.org/page.php?itemID=333) for details.

h. Follow-Up:

i. Once an action plan is agreed upon, the committee will draft a notification letter to the resident. This letter will be presented to the resident by their advisor and the committee Chair (or PD) ideally within seven days following the resident review meeting. Should the advisor be unavailable, this letter may be presented to the resident by the PD or another committee member.

ii. The committee may schedule an in-person meeting with the resident and their advisor to discuss action items for follow-up. The resident may choose to have the chief resident *present to advocate for them, in addition to their advisor, but the Chief Resident cannot be involved in remediation decision making.*

iii. It is strongly suggested to incorporate a committee member in resident-advisor meetings when the resident is on formal citation if able and desired by the resident or their advisor. This will provide external perspective and help track progress towards citation removal.

iv. The Resident is required to meet with the Behavior Health Education Director within 72 business days after each "notification" letter meeting.

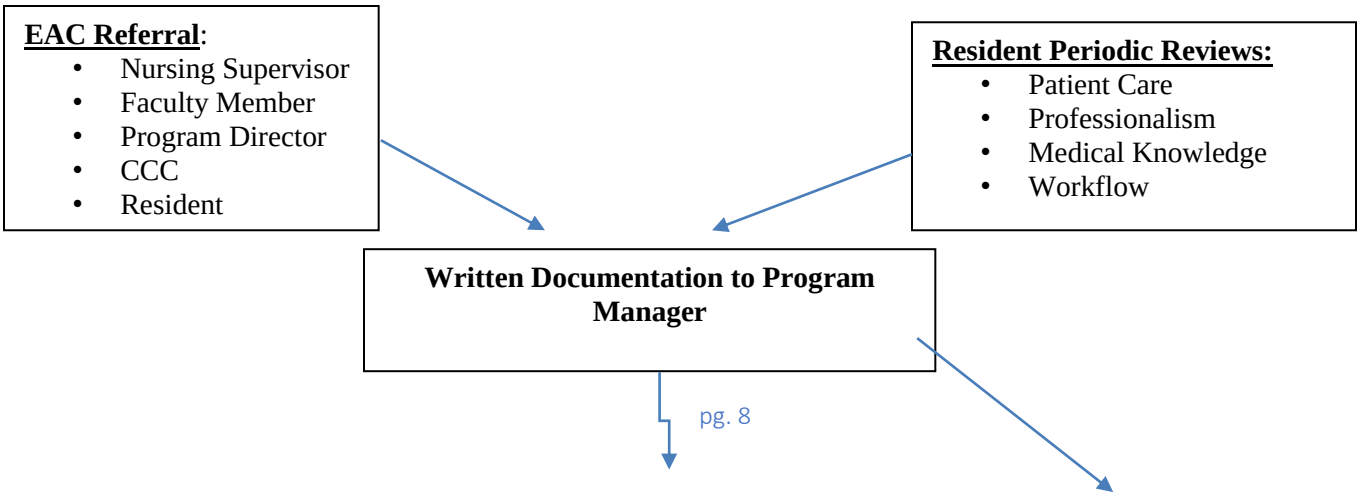
References: Smith, J. L., Lypson, M., Silverberg, M., Weizberg, M., Murano, T., Lukela, M., & Santen, S. A. (2017). Defining Uniform Processes for Remediation, Probation and Termination in Residency Training. Western Journal of Emergency Medicine, 18(1), 110–113. http://doi.org/10.5811/westjem.2016.10.31483

Community Health
of Central Washington

CWFM Residency Education and Advancement Committee (EAC)

Approved By: Program Director
Supersedes: 2/1/2021 **Effective Date: 7/2023**

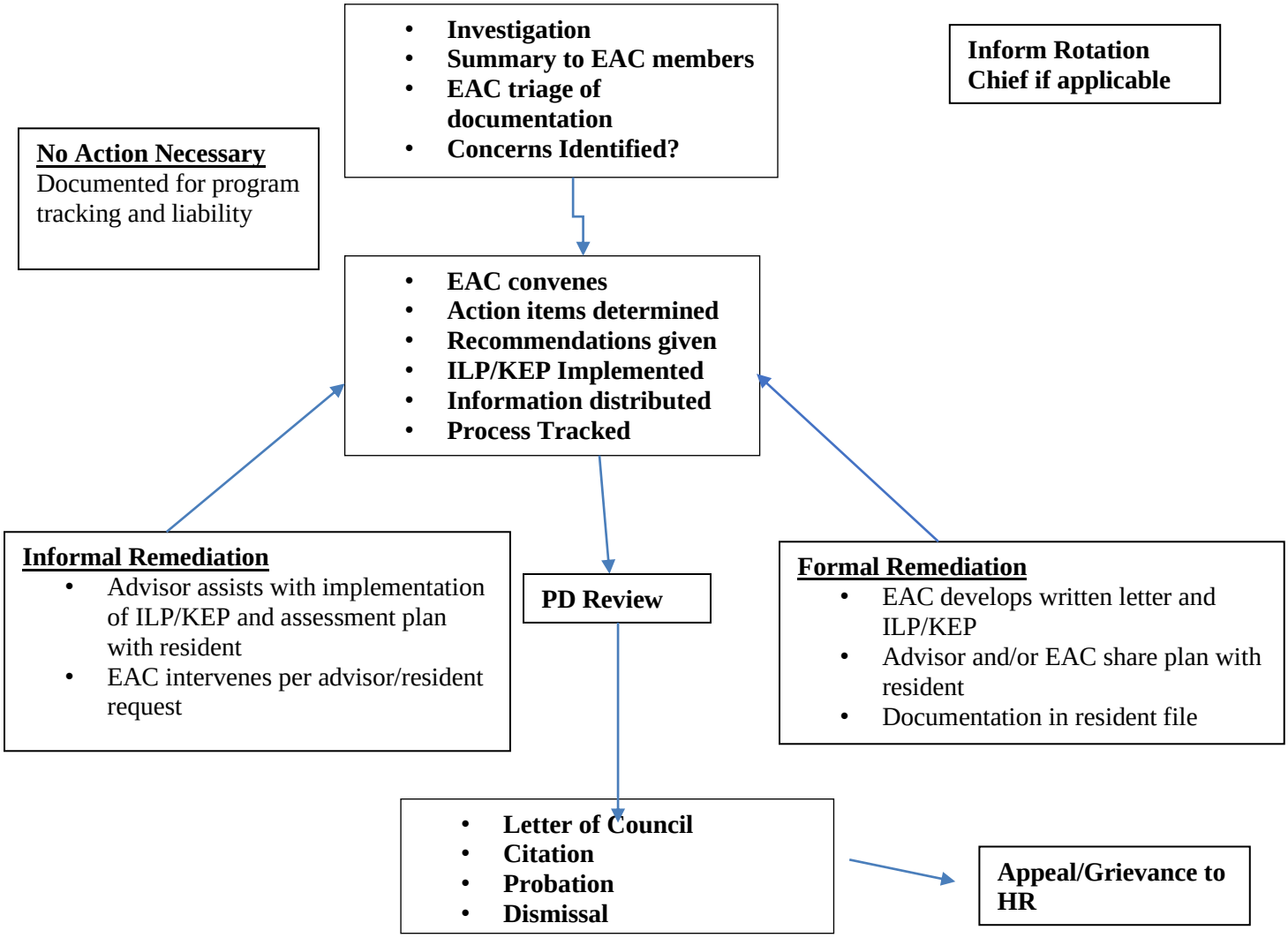
EDUCATION AND ADVANCEMENT COMMITTEE WORKFLOW (EAC)



Community Health of Central Washington

CWFM Residency Education and Advancement Committee (EAC)

Approved By: Program Director
Supersedes: 2/1/2021 **Effective Date: 7/2023**



Attachment D

GMEC Institutional Clinical and Educational Work Hours Policy
Community Health of Central Washington

Approved By: GMEC
Supersedes: **Effective Date: 7/17/2023**

Purpose: To maintain a clinical and educational work hour policy that ensures effective oversight of institutional and program-level compliance with ACGME clinical and educational work hour requirements.

Definitions:
Clinical and Educational Work Hours (formerly known as duty hours): are defined as all clinical and academic activities related to the training program. This includes inpatient and outpatient clinical care, inpatient night float, in-house call, transfer of patient care, and administrative activities related to patient care such as completing medical records, ordering and reviewing lab tests, and signing orders. This also includes time spent doing clinical work while moonlighting or other scheduled activities such as conferences. Clinical and Educational Work hours do not include reading done in preparation for cases, studying, and research done away from the duty site. Clinical and Educational Work Hours will hereafter be referred to as "Work Hours".

Continuous time on duty: The period that a resident is in the hospital (or other clinical care setting) continuously, counting the resident's regular scheduled day, time on call, and the hours a resident remains on duty after the end of the on-call period to transfer the care of patients and for didactic activities.

In-house call: Work hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

Scheduled work (duty) periods: Assigned work within the institution encompassing hours which may be within the normal work day, beyond the normal work day, or a combination of both.

Policy: Central Washington Family Medicine Residency, in partnership with Community Health of Central Washington (CHCW), must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities. (CPR VI.F) The residency program must meet the following requirements:

1. **Maximum Hours of Clinical and Educational Work per Week:** Work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (CPR VI.F.1)

   NOTE: *The ACGME does not allow compliance with work hour limits to be based on a rolling average. Averaging must be by rotation, aggregated over a four-week period for rotations of one calendar month or longer, or calculated within the duration of the rotation for rotations of less than four weeks in length. Compliance with all aspects of work hour limits must be achieved within a given rotation, regardless of duration (i.e., a two-week rotation of heavy duty and a two-week rotation of light duty may not be combined to achieve compliance). Further, vacation or leave days must be taken out of the numerator and the denominator for calculating work hours, call frequency or days off (i.e., if a resident is on vacation for one week, the hours for that rotation should be averaged over the remaining three weeks).*

2. **Mandatory Time Free of Clinical Work and Education:** Residents should have eight hours off between scheduled work periods. (CPR VI.F.2.b)
   a. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-in-seven requirements. (CPR VI.F.2.b.(1))
   b. Residents must have a least 14 hours free of clinical work and education after 24 hours of in-house call. (CPR VI.F.2.c)
   c. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (CPR VI.F.2.d)

3. **Maximum Clinical Work and Education Period Length:** Clinical and Education Work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (CPR VI.F.3.a) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (CPR VI.F.3.a.(1))

4. **Clinical and Educational Work Hour Exceptions:** In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient, or humanistic attention to the needs of a patient or family, or to attend unique educational events. (CPR VI.F.4.a) These additional hours of care or education will be counted toward the 80-hour weekly limit. (CPR VI.F.4.b)

5. **In-House Night Float:** Night float must occur within the context of the 80-hour and one-day-in-seven requirements. (CPR VI.F.6) The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.

6. **Maximum In-House On-Call Frequency:** Residents must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). (CPR VI.F.7)

7. **Fatigue Mitigation:** Program must educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; educate all faculty members and resident in alertness management and fatigue mitigation processes; encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (CPR VI.D) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (CPR VI.D.2) The program, in partnership with Community Health of Central Washington, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (CPR VI.D.3)

8. **Resident Requirements:** All residents are required to complete GME approved training arranged by their residency program. Programs may provide additional training to residents and must identify proper training methods for their faculty.

9. **Moonlighting:** Community Health of Central Washington has established a Resident Moonlighting policy to address moonlighting activities. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness to work nor compromise patient safety. (CPR VI.F.5.a)
    a. Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (CPR VI.F.5.b)
    b. PGY-1 residents are not permitted to moonlight. (CPR VI.F.5.c)
    c. Program may make additional limitations to moonlighting to ensure fairness and support resident education specific goals.

10. **Residency Program Policy Requirements:** CHCW requires that the ACGME-accredited residency program develop and maintain a policy on resident work hours. Program policies must meet the educational objectives and patient care responsibilities of the training program and must comply with work hour limits according to specialty-specific Program Requirements, the Common Program Requirements, and the Institutional Clinical and Educational Work Policy. In addition, the policy must also address:
    a. How the program monitors work hours, according to CHCW institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements.
    b. Protocols for adjusting schedules as necessary to mitigate excessive service demands and/or fatigue.
    c. How the program monitors the need for and ensures the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged.
    d. Mechanisms used by the program to ensure residents and fellows report their work hours (including program assigned work hours, and moonlighting activities, if applicable) in New Innovations.

11. **Applicability:** This policy applies for all training activities, regardless of location of the resident training experience.

12. **Records / Monitoring:** Records of program work hour policies are maintained by the residency program office in New Innovations. All residents are required to track their work hours via New Innovations. Residents approved for internal and external moonlighting activities are also required to report work hours in New Innovations.

    a. Clinical and educational work hours compliance must be monitored by the program and will be reviewed by the Graduate Medical Education Committee (GMEC) quarterly by the Institutional Clinical and Educational Work Hours Report. GMEC shall investigate and take action (such as a special review) if the program is found to not be in compliance with the work hours limits (e.g., 15% or more of residents reporting violations) or reporting requirements (less than 70% of shifts reviewed).

13. **Reporting Concerns:** Residents are encouraged to contact the Education Advancement Committee with concerns or confidentially submit concerns via the CHCW EMS incident reporting software. The program director will be required to submit a corrective action plan to the Designated Institutional Officer (DIO) within 30 days of receipt of the complaint.

GMEC Institutional Clinical and Educational Work Hours Policy
Community Health of Central Washington

Approved By: GMEC
Supersedes: **Effective Date: 7/17/2023**

References:

1. ACGME Institutional Requirements, latest edition, published online at https://www.acgme.org/programs-and-institutions/institutions/institutional-application-and-requirements/

2. ACGME Common Program Requirements, latest edition, published online at https://www.acgme.org/programs-and-institutions/programs/common-program-requirements/

3. ACGME Family Medicine Program Requirements, latest edition, published online at https://www.acgme.org/specialties/family-medicine/program-requirements-and-faqs-and-applications/

Attachment E

CWFM Residency Moonlighting Policy

Approved By: GMEC
Supersedes: 8/2020 **Effective Date: 7/2023**

Purpose:
PGY-3 residents may request approval from the program director to Moonlight. The Program Director must ensure that approved moonlighting activities do not interfere with the ability of residents to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety (CPR VI.F.5).

Policy: A resident must be employed full time by Community Health of Central Washington (CHCW) and the employment beyond the scope of residency training (moonlighting) is not required and is permitted only with the written permission of the Designated Institutional Official/Program Director. Moonlighting hours count toward the ACGME Maximum Hours of Clinical and Educational Work per Week requirements (CPR VI.F.1) and the American Osteopathic Association (AOA) duty hour standards. CHCW may prohibit moonlighting that interferes with resident education.

Procedure:

1. The resident seeking permission to moonlight must:
    a. Be and remain in good standing
    b. Have a passing equivalent on American Board of Family Medicine and American College of Osteopathic Family Physician In-Training Exams
    c. Have passed the USME or COMLEX Step 3 exams
    d. Provide written documentation to the DIO/PD that he/she is covered for any liability action which could arise from the moonlighting activity
    e. Demonstrate licensure appropriate for the planned activity
    f. Submit to the DIO/PD a written request noting the moonlighting activity and its benefit to the resident
    g. Maintain his/her level of performance during the moonlighting period in all residency program educational activities without demonstration of undue fatigue

2. The DIO/PD will:
    a. Review the resident's request for moonlighting
    b. Issue a written statement of permission or denial of the request
    c. Monitor the effect of the moonlighting activities on the resident's performance in the program
    d. Withdraw permission to moonlight if adverse effects are noted

3. CHCW or the residency program may prohibit moonlighting by its residents if moonlighting is deemed to interfere with the educational goals and objective of the program.

Job Title: PGY-1 Resident
Department: Residency
Supervisor: Program Director
FLSA Status: Non - Exempt

Prerequisites

- Medical doctorate from an allopathic or osteopathic medical school
- Passing scores on the USMLE Step 1 and USMLE Step 2 CK or COMLEX Level 1, and Level 2 CK.
- Foreign medical graduates: all ECFMG requirements completed.
- Eligibility for State of Washington Family Physician training licensure Application through Electronic Resident Application System (ERAS) or NRMP Match Exemption

Qualities

- Possess the attitudes, knowledge, and skills needed for learning broad-spectrum family medicine.
- Demonstrate effective interpersonal skills with a diverse population that include patients, medical staff, faculty, other residents, nursing staff, and medical office personnel.
- Work within multiple teams that include inpatient rounding teams, curriculum development teams, outpatient care teams, and support groups.
- Communicate effectively in English both verbally and in writing.
- Have the emotional maturity to self-assess, know own limitations and seek advice or counseling in situations that might impair own learning or performance in the care of patients, and to proactively seek appropriate treatment. This can include but is not limited to substance use disorders and chemical dependency disorders.

Management of Mental and Physical Demands, Environment, and Working Conditions

- Work using sterile technique, universal body secretion precautions, and respiratory isolation equipment.
- Move around the hospital, clinic, and outside rotation sites adequately to address routine and emergency patient care needs.
- Use diagnostic equipment essential to family medicine including the ophthalmoscope, stethoscope, and ultrasound.
- Palpate, percuss, auscultate, and perform diagnostic maneuvers. Assess and interpret heart sounds and breath sounds.
- Read and interpret patient charts and monitoring equipment.
- Manage multiple patient care duties simultaneously.

- Use judgement and make decisions regarding complicated and undifferentiated disease presentations that are timely and appropriate for the situation in ambulatory, emergency, and hospital settings.
- Adhere to the outpatient and inpatient Family Medicine and obstetrics PGY-1 curriculum goals and expectations for patients per clinic, admissions and patient care assignments, and have the ability to complete appropriate documentation in a timely fashion.
- Adapt to changing environments, display flexibility and function in the face of uncertainties, inherent in the clinical problems of patients.
- Work shifts of varying lengths and scheduled including daytime, evening, and overnight shifts.
- Work shifts up to 24 hours + 4 hours of continuity care (up to 28 hours) on inpatient services.
- Be able to participate in multiple patient care settings, including but not limited to Hospitals, Outpatient Clinics, Operating Rooms, Labor and Delivery Departments, Emergency Departments, and Mobile Care Units.
- Drive or find transportation to and from required rotations up to 60 miles away.
- Demonstrate professional work habits including arrival at assignments on time, properly attired, and remain at the assigned location for the assigned time period. Arrive at rotations by listed start time despite inclement weather, level of light, or road conditions. In the event of an emergency which will prevent this, this needs to be communicated immediately to the residency.
- Must have computer and typing skills sufficient to be able to use email, electronic health records, and internet-based databases for literature review, patient care documentation, data retrieval, and procedure documentation. Communicate complex medical information rapidly and effectively with other members of a health care team.
- If a Resident Matches to Ellensburg, they must live within a 20-minute drive of Kittitas Valley Hospital.

Performance Responsibilities and Job Functions

Outpatient Care

- Provide longitudinal primary medical care to a panel of ambulatory patients.
- See a broad spectrum of undifferentiated patients with an emphasis on quality of patient evaluation and care.
- Learn to perform procedures essential to family medicine (must be performed with approval and direct supervision of Attending).
- Work effectively within a patient-care team.
- Complete clinic notes, procedure notes, referral requests, and other required documentation in a timely fashion.
- Demonstrate timely, consistent, and reliable follow-up on patient care, such as laboratory results, patient phone calls, or other requests.
- Work effectively with medical staff on specialty outpatient rotations.
- Identify and report medical errors and near misses using clinic-based reporting systems.

Inpatient Care

- Perform complete H&Ps on new hospital admissions and patients presenting for emergency evaluation.
- Perform the initial assessment of the patient and actively participate in all aspects of patient care including history and physical, diagnostic and therapeutic planning, procedures, writing orders, and interactions with families.
- Perform CPR on infants and adults as indicated.
- Manage laboring women, perform deliveries, and repair obstetric trauma under the supervision of a family physician or obstetric Attending as well as assist with OB/GYN procedures.
- Write and/or dictate admission and discharge notes, progress notes, delivery notes, and other necessary hospital documentation in a timely fashion.
- Write orders for physical and chemical restraints and seclusion, as necessary.
- Communicate with all care team members and respond to patient care needs promptly.
- Triage patient care duties to identify and address most acute first.
- Identify and report medical errors and near misses using hospital-based reporting systems.
- Provide afterhours medical call service for CHCW with supervision as needed from senior residents and attendings.

<u>Educational Mission</u>

- Present educational material in formats appropriately adjusted for the audience (i.e., medical students, peers, medical staff, or community groups).
- Complete and pass all required rotations.
- Provide feedback to the program spontaneously, when informally requested, and on formal evaluations.
- Perform an academic self-assessment at least twice a year.
- Participate in curriculum development through the work of standing committees.
- Develop continuing Quality Improvement projects in conjunction with residency and faculty.
- Promptly complete logging for procedures, patient encounters, and work hours.
- Promptly complete administrative tasks required for maintenance of licensure and credentialling.