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Department of Family Medicine Mission Statement

With a deep commitment to the social justice in the Catholic, Jesuit tradition, the Department of Family Medicine will provide:
- Skilled and respectful education to our students, residents, physicians, and community
- Comprehensive and compassionate care to our patients
- Broad-based outreach to those in need, and
- Scholastic excellence in all our endeavors.

Creighton University School of Medicine Mission Statement

In the Catholic, Jesuit tradition of Creighton University, the mission of the School of Medicine is to improve the human condition through excellence in educating students, physicians and the public, advancing knowledge, and providing comprehensive patient care.
EDUCATION
ACGME SIX COMPETENCIES

At its February 1999 meeting, the ACGME endorsed general competencies for residents in the areas of:

**Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

**Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

**Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

**Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals

**Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

**Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value
Eligibility Requirements for Certification

All candidates for the American Board of Family Medicine Certification Examination must have satisfactorily completed three years of training (a full 36 calendar months with 12 months in each of the PGY-1, PGY-2, and PGY-3 years) in a Family Medicine residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) subsequent to receipt of the M.D. or D.O. degree from an accredited institution, or receipt of a Standard Certificate from the Educational Commission for Foreign Medical Graduates (ECFMG). If a physician does not meet the eligibility requirements of the ACGME for residency training in Family Medicine, his/her training will not be recognized by the Board.

Candidates who obtained their M.D. degree from medical schools in the United States or Canada must have attended a school accredited by the Liaison Committee on Medical Education or the Committee for Accreditation of Canadian Medical Schools. Candidates who obtained a D.O. degree must have graduated from a college of osteopathic medicine accredited by the American Osteopathic Association.

All applicants for the Certification Examination are subject to the approval of the Board, and the final decision regarding any application rests solely with the ABFM. No candidate will be allowed to take the examination until all fees are paid and all requirements have been satisfactorily met.

Satisfactory Completion of Residency

The Board prefers all three years of postgraduate training to be in the same ACGME-accredited Family Medicine program; however, other training may be considered as equivalent (e.g., Flexible/Transitional Year, AOA Osteopathic Internship, etc.). In these cases and for physicians who have had international training, the American Board of Family Medicine requires residency programs to notify the ABFM of residents who are entering training with A/P credit. If the Program Director fails to comply, the Board will determine the amount of transfer credit at the time of its discovery of the transfer. Consequently, the resident may receive less credit toward certification than anticipated and may be required to extend the duration of training.

The last two years of Family Medicine residency training must be completed in the same accredited program. Transfers after the beginning of the PGY-2 year are approved only in extraordinary circumstances.

All candidates' education and training experiences are subject to review and approval by the ABFM.

For more information, please visit the Home Page for the American Board of Family Medicine at https://www.theabfm.org/
CONFERENCES

Conferences

(1) Conferences should reflect the needs of the program and the residents. At least one faculty should attend each conference given by residents, and residents must not be the majority of presenters.

Each program must have the following:

(a) an educational rationale for use of conferences for the program;
(b) a statement on how conferences are evaluated and how the resultant data are used by the program; and,
(c) an explanation of resident involvement in conference design and presentations.

ACGME Program Requirements for Family Medicine IV.A.3.c

Attendance

Attendance at Core Content lectures, Grand Rounds, and M&M conferences is a requirement of this residency program. Core lecture time, as well as Grand Rounds, M&M conferences, Journal Club, Resident Meetings and Clinic Meetings, are protected times from other duties (i.e., rotations, clinics, etc.). Those who are post-call (i.e., beyond the 30 hour work shift) are exempted from core content and conferences. Lectures are downloaded in New Innovations in both PowerPoint and podcasting format and can be accessed from any computer with an internet connection.

Residents must attend 70% of the conferences in order to successfully advance to the subsequent year in residency or graduate from the program.

Educational Rationale

Conference topics are based on the following:

- those topics required by the RRC
- those topics that need to be mastered by residents early in their training for patient care
- those topics that were determined to be best presented in conference format, either annually or every three years.

M&M, Journal Club and Grand Round topics are discussed with the medical director and approved by him prior to presentation.

Other medical knowledge topics are covered in the objectives of each rotation.

Conference Evaluation

Conferences are evaluated by the residents and the results are sent to the faculty members presenting the conferences as feedback for improvement. These evaluations are anonymous. In addition, the Program Director attends most conferences to ensure that they are satisfying the needs of the residency program. Those conferences that are not design for Family Physicians are eliminated from the conference schedule.

Resident Involvement in Conference Design and Presentation

There is one resident representative from each class on the Education Committee. This group has been involved in the development of the new curriculum that becomes effective July 1, 2008. All future changes to the curriculum will be discussed and approved by the Education Committee.
EDUCATIONAL GOAL

The curriculum must contain the following educational components:
1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;
2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation. ACGME Program Requirements for Family Medicine, IV.A

Our Educational Goal is to form Family Physicians competent in the Six Competencies of Medical Education and the procedures commonly performed by Family Physicians in clinical practice.

To achieve this goal, we are basing our method of teaching and evaluation on Dreyfus’ Taxonomy of Learning, developed in 1986. We are grateful to the University of Texas Health Center at Tyler for their original work in this area.

Dreyfus’ Taxonomy has five stages:
- Novice
- Advanced Beginner
- Competence
- Proficiency
- Expertise

In applying this to medical knowledge acquisition, we are applying these terms to the following stages of medical and residency education:

First and Second Year Medical Student
Novice: Knowledge Acquisition
- Fundamental Knowledge of Disease Process.

Third and Fourth Year Medical Student
Advanced Beginner: Knowledge Application
- Ability to apply knowledge to assessment and plan.

First Year Family Medicine Resident
Competency: Ability to perform
- Competent in top disease processes in all first year rotations
- Competency in acute care management in the Family Medicine Center with experience in chronic disease management.
- Competency in non-critical care management on the Family Medicine Inpatient Rotation.

Second Year Family Medicine Resident
Proficiency: Advancement in knowledge or skill
- Proficient with increased demands and stress (night supervisor, continuity numbers)
- Competency in acute and chronic disease management in the Family Medicine Center.
- Competency in critical and non-critical care management on the Family Medicine Inpatient Rotation.

Third Year Family Medicine Resident
Expertise: Having, involving, displaying special skill and knowledge derived from training or experience.
- Innovator in Developing Projects to Improve Patient Care (Community Medicine, Practice Management)
- Competency in leadership skills while supervising the Family Medicine Inpatient Rotation.
- Expertise in integrating all aspects of Family Medicine independently and competently

This has been applied to our curriculum and can be found on our website under “Educational Goals.”
GOALS AND OBJECTIVES OF ROTATIONS

The curriculum must contain the following educational components:
1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;
2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;
   
ACGME Program Requirements for Family Medicine IV.A.

The Goals and Objectives are found both in New Innovations and on the Department of Family Medicine’s website under Program Curriculum at:

http://www2.creighton.edu/medschool/family/residency/curriculum/index.php

The goals and objectives are reviewed with all residents at the beginning of each year. In addition, these are sent to the residents via email from New Innovations prior to each rotation. Each resident must electronically sign the goals and objectives within 5 days of the beginning of the rotation, indicating that he/she has reviewed them.
HOME VISITS

Each resident must perform at least two home visits with at least one being for an older adult continuity patient. Faculty must supervise all home and nursing home care either on site or by prompt chart review as is appropriate based on a resident’s level of expertise and competence.

ACGME Program Requirements for Family Medicine, IV.A.5.a.2.iii

All residents are required to perform a minimum of two home visits during their residency. At least one of these patients must be a geriatric patient (over the age of 65 years).

It is the responsibility of the resident to identify the patient he/she wishes to visit during the Management of Health Systems Rotation and to arrange for the visit prior to the assigned day for the visit. If the resident does not complete both home visits during that time, he/she will need to make up that visit on their own time.

Effective July 1, 2008, new residents will have their home visits scheduled during the Orientation/Community Medicine month.

All home visits need to be supervised either during the visit or immediately after the visit with the program director. All visits must be documented in the Home Visit log book in New Innovations, as well as in the patient’s chart at the Family Medicine Center.
IN-TRAINING EXAMINATION

The American Board of Family Medicine In-Training Examination is a cognitive examination given annually on the first Friday in November. All residents are released from other rotational responsibilities in order to be present for the examination. The participating residents remain anonymous to the American Board of Family Medicine. The examinations are scored by the Board, but the results are reported using a code number assigned by the Program Director, thus preserving the resident’s anonymity.

The In-Training Examination is similar in emphasis and format to the Certification Examination. It consists of items written to test the core of knowledge and patient management skills in eight major areas: Internal Medicine, Surgery, Obstetrics, Community Medicine, Pediatrics, Psychiatry and Behavioral Sciences, Geriatrics, and Gynecology. The physicians who write the test items, as well as the members of the special committee who review them, include both practicing clinicians and teachers in Family Medicine residency programs.

The Program Director and faculty will review both current and past test results to determine if a resident is demonstrating improvement on each successive year’s results and to ensure that a resident is ready for the Certification Examination at the end of his/her residency training.
LIFE SUPPORT CERTIFICATION

All Family Medicine Residents are required to have current Basic Life Support (BCLS), Advanced Cardiac Life Support (ACLS), Neonatal Advanced Life Support (NALS) and Pediatric Advanced Life Support (PALS) certification.

Certification sessions are held during the Orientation month for new residents. Senior residents are responsible for maintaining their certification throughout their residency and signing up for recertification following the Department Leave Request policy.

Advance Life Support in Obstetrics (ALSO) and Advance Trauma Lift Support (ATLS) are strongly recommended. These are not paid for by the Department of Family Medicine.

Be advised that current certification in BCLS and ACLS is necessary to advance to the next year of postgraduate training and to obtain appropriate salary increases.
PROCEDURE DOCUMENTATION

The program director...must devise a method by which all procedures are supervised and evaluated. The program director and faculty must also devise a credentialing process to establish whether or not a resident is competent to perform specific procedures. The resident’s documentation of procedural learning should include procedure, age and gender of patient, level of performance (e.g., progressing toward independent performance), and number of procedures performed before independent status is granted. Procedural teaching should include didactic presentations, indications and contra-indications, risks and benefits, informed consent, appropriate coding and charging, management of aftercare and complications, and acquisition and maintenance of skills.

ACGME Program Requirements for Family Medicine, II.A

Family Medicine residents have the opportunity to perform many procedures in both the inpatient and outpatient setting on a number of rotations throughout the course of training. Each resident will need to track and record all procedures on New Innovations. A printed document of procedural data can be generated and downloaded from this database. It is the resident’s responsibility to record and maintain the procedure log. This log book will be the basis for whether or not a resident is given hospital privileges to perform procedures upon graduation.

Procedural teaching will take place via an annual CME Surgical Skills Workshop sponsored by the Department of Surgery, didactic presentations and workshops, and on various rotations throughout the residency period.
Residents’ Scholarly Activities

1. The curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

2. Residents should participate in scholarly activity. Each program must provide supervised experiences for all residents in scholarly activities such as research, presentations at national, regional, state, or local professional meetings, or presentation and/ or publication of review articles and case presentations. Formal instruction and practical experience must assure that each resident develops and demonstrates skills in locating sources of scientific data pertinent to the care of patients, analyzing the appropriateness of research design and statistical methods, obtaining information about diagnostic and therapeutic effectiveness, and applying evidence from pertinent clinical studies to patient care. The program must provide a supervised, ongoing forum in which residents explore and analyze emerging scientific evidence pertinent to the practice of family medicine. Additionally, all residents must actively participate in scientific inquiry, either through direct participation in research, or undertaking scholarly projects that make use of the scientific methods noted above. Residents must also have guided experiences in the application of emerging clinical knowledge applicable to their own patient panels. The training environment must be in compliance with accepted evidence-based practices.

3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

ACGME Program Requirements for Family Medicine, IV, B

To accomplish this goal, all residents will be expected to write a peer review journal article intended for publication during their residency. The time line is as follows:

1st Year: Determine topic of interest with guidance from faculty advisor and submit proposal to faculty advisor and the Scholarly Activity Committee. Acceptable forms of Scholarly Activity include: Research Paper, Peer-Review Journal Article, Case study submitted for publication, Poster Presentation at a local, state or national meeting, or a scholarly presentation at a local, state or national meeting.

2nd Year: Prepare the project and submit for evaluation to the faculty advisor and Scholarly Activity Committee.

3rd Year: Publish or Present your Scholarly Activity.
PATIENT CARE
Continuity of care is a recognized core value of the specialty of family medicine and must be a priority in each program. Continuity may pertain to individuals or to the practice in its entirety.

(i) Resident panels must include continuity patients requiring home care and care in long-term care facilities to provide each resident with continuity experience in those settings.
(ii) Nursing home experience must consist of at least two patients as a continuity experience over a minimum of 24 consecutive months, in addition to that which residents might experience as part of a rotation.
(iii) Additionally, each resident must perform at least two home visits with at least one being for an older adult continuity patient. Faculty must supervise all home and nursing home care either on site or by prompt chart review as is appropriate based on a resident's level of expertise and competence.
(iv) In order to coordinate and integrate each patient's care and to optimize each resident's continuity training, the program must require that each resident maintain continuity of responsibility for some of his or her patients in all settings when such patients require urgent or emergent care, home care, long-term care, hospitalization or consultation with other providers.

Continuity of responsibility should include active involvement in management and treatment decisions, and interactive communications about management and treatment decisions. In the second and third years of residency, when other curricular responsibilities temporarily prevent a resident from providing continuity of responsibility in any of these settings, that continuity must be provided by another resident or faculty from the program (i.e., the inpatient team or the physician on-call for the practice). When a substitute physician, such as a member of a family medicine team, is involved in continuity of care, there must be a mechanism to transfer information clearly and expeditiously to the primary continuity physician.

ACGME Program Requirements for Family Medicine, IV.A.5.a.2.a.

The three-year FMC experience for each resident must include a documented total of at least 1650 patient visits, with at least 150 visits occurring in the first year. The number of patient visits from resident participation at a second FMC and/or from other longitudinal clinics may be counted toward the total number of patient visits if these visits are supervised by family physician faculty and if it can be documented that these patients are seen in continuity by the residents.

ACGME Program Requirements for Family Medicine, IV.A.5.a.2.c.iii.c

Continuity patients are assigned to the Family Medicine Resident at the Family Medicine Center and at St. Joseph Villa Nursing Home.

Residents must meet the following continuity patient numbers before they can advance to the next year of training or graduate:

PGY-1: 150 continuity patients
PGY-2: 650 continuity patients
PGY-3: 1,650 continuity patients

Each resident is responsible for maintaining continuity and direction of his/her patients' care. When patients from the Family Medicine Center are admitted to CUMC, they are admitted to the Family Medicine inpatient service for management. The continuity resident is responsible for writing notes on their continuity patients every day of their patient's admission (excluding weekends and holidays). The primary management will be done by the attending and residents on the inpatient service. It is expected that the patient's resident physician will participate in the patient's discharge planning and ensure timely
personal follow-up at the FMC. The Supervising Resident of the Inpatient Service will notify the continuity resident of an admission within 24 hours of the admission.

**Family Medicine Center (FMC)**

The Family Medicine Center serves as the clinic for residency education. The Family Medicine Center is the primary focus of outpatient training for our residency program. As such, clinic time is protected from the demands of the residency training in order to provide the continuity of care that is expected of Family Physicians. To ensure this goal, the following policies have been enacted:

1. Morning office hours start at 9:00 a.m. and conclude at 12:00 noon. Afternoon office hours begin at 1:00 p.m. and conclude at 5:00 p.m. Residents are expected to be present in the clinic during clinic hours. If an illness or emergency prevents a timely arrival, residents MUST notify The Medical Director by pager or phone call immediately.

2. All first year residents should see a minimum of 3 patients per clinic. All second year residents should see a minimum of 5 patients per clinic. All third year residents should see a minimum of 7 patients per clinic. Walk-ins will be added to the schedule on the day of clinic.

3. There will be no early dismissals from clinic. If you have seen the last clinic patient for the day, use the time to complete charts, read medical literature, discuss cases with The Medical Director or the preceptor, and/or see additional walk-in patients.

4. Residents on the inpatient team will need to present at 8:30 am, then depart immediately for clinic. The on-call resident and the night supervisor will have patients scheduled through 4:00 on clinic days. However, these residents will be allowed to leave at 4:45 pm AFTER checking out with The Medical Director.

5. At no time is a resident allowed to cancel a clinic or block off time from the clinic schedule without permission from The Medical Director. Clinics will be cancelled only in the event of an emergency, illness, or for vacation time. If an emergency or illness prevents you from attending clinic, you must inform the front desk immediately at 280-3987. You must also contact The Medical Director to authorize the absence. The clinic will then inform the Family Medicine administrative office of the resident's absence from clinic.

6. For vacation requests, please see the vacation policies elsewhere in this manual under “Time Away from Program” for specific information on requesting leave.

7. Patient charts are to be filled out promptly after seeing the patients. All charts must be completed prior to the end of your clinic shift.

8. Residents should check their individual mail slots at the beginning of each continuity clinic. All charts that require completion or signatures should be promptly completed. Lab results should be reviewed and a brief description noted on any actions to be taken. Results must be initialed and dated before they are placed in a patient's chart. For all abnormal results, paps, labs, x-ray results, etc., a clear notation that a plan of action is in place must be documented before the result is filed in the patient's chart. Any follow-up instructions for the medical assistant must be clearly written on the test with date and signature.

9. First year residents must have a preceptor present for all patient encounters during the first six months of residency. Following this, at the attending’s discretion, residents may present their patients to the attending physician after the initial exam to discuss the treatment plan.
10. Residents are expected to follow a dress code of professional attire. Scrubs are not allowed to be worn during clinic hours.

11. All narcotic prescriptions must have a copy made for chart record. Always document medications prescribed on exam note with amount and strength. Patients requiring long-term narcotic use must sign a contract stating that no other physician may prescribe narcotics and that the patient must follow-up with the presenting resident monthly for refills. These contracts are available at the clinic on preprinted forms.

**Saint Joseph Villa Nursing and Rehabilitation Center**

St. Joseph Villa Nursing and Rehabilitation Center, located at 2305 S 10th Street, 345-5683, is a nursing home where most of our nursing home patients reside. Dr. Frey, Department Chair, is the Medical Director of the facility. The facility has an Alzheimer’s unit. It is similar to most nursing homes in its layout and limitations. Each resident is assigned nursing home patients to visit and provide care for on a longitudinal basis during their three years of residency training.

**Frequency of Visits**

All new admissions to the center require a current history and physical. If one is not sent with the patient when they arrive at the center (it must be less than 5 days old), the responsibility falls on the medical staff at the center to complete this. Generally, the medical records group at the Villa will type a statement for the resident to review, date, and/or change. When a resident is assigned a new patient who has recently arrived at the Villa (with an updated H&P already complete), the resident is to see the patient within 48 hours of the assignment being made.

As for frequency of visits, Medicare requires:

“The resident (patient) must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.”

“The timing of the physician visits is based on the admission date of the resident (patient). Visits will be made within the first 30 days, and then at 30-day intervals up until 90 days after the admission date. Visits will then be at 60-day intervals. Permitting up to 10 days of slippage of a due date will not affect the next due date. However, do not specifically look at the timetables for physician visits unless there is indication of inadequate medical care. The regulation states that the physician (or his/her delegate) must visit the resident (patient) at lease every 30 or 60 days. There is no provision for physicians to use discretion in visiting at intervals longer than those specified.”

It is expected that all residents will see their patients monthly. Proper documentation is required for all visits. All visits to St. Joseph Villa must be documented in the “St. Joe Villa Patients” log book in New Innovations. In addition, all visits to a patient must be supervised immediately after the visit by paging Dr. Frey.

**General Guidance on Visits**

Resident nursing home visits consist of:

1. Obtaining pertinent subjective data from the patient and nursing personnel.
2. Examining the patient.
3. Reviewing the past medical history and diagnoses lists.
4. Reviewing the medication lists.
5. Writing a brief note on the chart.
During Monday through Friday business hours, the resident may be paged about their nursing home patients by the nursing staff. Residents are to address these calls appropriately, which in some cases may require a visit that day to the nursing home to see the patient and render care. In some cases, hospitalization will be required. The appropriate faculty member should be notified in these circumstances.

A current list of St. Joseph Villa patients can be obtained from the Program Director.
EMERGENCY DEPARTMENT ADMISSION PROCESS

1. Patient is admitted to the Emergency Department (ED).

2. ED physician assesses the patient and it is recommended that an admission be considered.

3. The Emergency Department will contact the admitting service of the recommended admit.

4. The resident of the admitting service will come to the ED, assess the patient, contact the admitting physician to discuss the plan of care and recommended admission. It is essential that this step be expedited. A full work-up should not be completed before contacting the admitting physician.

5. If the admitting physician agrees with the recommendation to admit, the resident will ask the admitting physician what status they would like the patient to be in – observation or inpatient. The resident will then complete the designating patient type form. By completing this, the resident is taking a telephone order from the admitting physician for the admission.

6. Once Step 5 is completed, the HUC in the ED will contact the house supervisor (HS) or patient placement nurse (PPN) to inform of the admission and need for a bed and IQ screening. That form is also faxed to the bed placement office at 449-4868 Monday-Friday, 7 am to 5 pm, or the fax number requested by the house supervisor/case manager doing pre-admit process. The original should accompany the patient to the admitting unit to be placed in the chart.

7. Once the patient placement nurse or house supervisor reviews the admission for IQ criteria and determines the admission status is appropriate, they will notify the registrar to proceed with the admission. The patient placement nurse or house supervisor will fax the admit order sheet to the ED registration or convey all needed information to them by phone.

8. ED registration will then notify the ED HUC of bed assignment. (The HS /PPN will not call the ED back with this information.)
OBSTETRIC PATIENTS

All Family Medicine Residents are required to follow obstetrical continuity patients. After residency each individual may personally determine whether to practice obstetrics. However, in residency everyone will obtain the necessary training and represent our program well.

Continuity of OB Patients

During residency each residency is required to provide continuity care to obstetrical patients through the prenatal, perinatal, and post-partum course. The Family Medicine Review Committee (RC), which accredits residency programs, require that:

“Each resident must perform a minimum of 40 deliveries over the 3-year program, of which a minimum of ten must be continuity deliveries. At least 30 of the total deliveries must be vaginal deliveries. Two residents may be given credit for the same delivery of one of those residents is supervising. The experience of each resident must be documented as to the role played in the delivery.”

ACGME Program Requirements for Family Medicine, IV, A, 5, b, 3

The RC defines continuity OB patients as a patient who has had at least one prenatal visit, had a delivery performed by the continuity resident, and one post-partum visit. A supervising resident may receive credit only after he/she has complete the required 40 deliveries.

When a patient presents with a confirmed pregnancy and is seen for the first OB physician visit, a full physical, pap, pelvic are performed. The resident then follows the patient through the balance of the pregnancy by adhering to accepted OB standards. At 32 weeks, copies of the patient’s records are forwarded to the Department of Family Medicine at CUMC so that the patients’ files are readily available when she comes into the hospital in labor.

When a continuity patient arrives in L&D for triage, the on-call resident is paged who will subsequently notify the supervising resident to evaluate the patient and to perform the history and physical exam. If the patient is in labor, the continuity resident will be notified by the supervising resident. Residents are expected to be present in the hospital throughout the patient’s labor so that they are ready when delivery is imminent. Being present throughout the labor also allows the resident to follow the progress and alert the staff if any complicating factors arise.

The on-call Family Medicine OB staff is to be called for all deliveries. Please allow adequate time for them to arrive, if at all possible. Instrumentation deliveries should only be done with appropriate staff present (those who have corresponding privileges). All “High Risk” deliveries must have an OB consultant on the chart; this includes preterm, pre-eclamptic, and surgical deliveries.

Following the delivery, the continuity resident is to arrive each morning and see/evaluate the mother and the baby. They are to write a note on the charge of each patient (mother and infant) unless otherwise arranged, and alert staff of the patient’s condition daily. The continuity resident should prepare the patient(s) for discharge at the appropriate time and prepare the patient(s) for the standard follow-up.

NOTE: You must ask another resident to cover your continuity patients if you are going on vacation. If a resident is going to be unavailable for their continuity patients, it is their responsibility to notify L&D and the primary inpatient team. Failure to do so causes an undue burden on the inpatient team and may threaten continuity and patient care.
Staff Obstetrics Patients

A number of our faculty have private OB patients and the logistics of the patient’s labor and delivery course is essentially the same as that of the resident continuity patient. Be sure to call the appropriate staff when a patient arrives and is evaluated in L&D. The staff physician will want to know of the patient’s arrival.

Policies Regarding Obstetric Admissions

1. OB consults should be approved by the Family Medicine attending unless an emergent situation arises.

2. Residents need to inform the inpatient team supervisor who is covering your OB patients if you will be unable to do so yourself.

3. Delivery of continuity OB patients will take place at Creighton University Medical Center only.

4. All inductions of labor are to be approved by Family Medicine attending prior to initiating the induction.

5. When a patient is admitted to L&D during daytime/office hours, staffing is typically done by notifying Dr. Frey. However, any available OB-practicing Family Medicine faculty member may staff OB patients during daytime hours.

6. On-call faculty covering OB calls and deliveries begins at 4:30 p.m. on weekdays. Any OB patients who will be or anticipate being in L&D after 4:30 p.m. should be checked out with a plan of care to the on-call staff.

7. Laboring patients in L&D need to be assessed with appropriate chart documentation every two (2) hours. The responsibility for these assessments and chart notations lies with the resident who is the primary continuity provider for that OB patient. Coverage for these assessments among residents is certainly allowed, provided communication is clear and precise. It is absolutely imperative that residents provide a clear coverage of OB care when not available to do so themselves (i.e., vacation, on-call at Children’s, etc.).

8. First year residents are not to manage OB patients or be assigned continuity OB patients until they have completed their OB rotation. However, first year residents on primary call without OB experience should accompany the resident on backup call for calls to L&D whenever possible (i.e., when not involved in other patient care matters). Experience and familiarity with the triage and care of the OB patient can be gained from such experience.

9. Every effort will be made to distribute OB patients equitably among the residents. Bearing in mind that some residents have a greater proclivity for OB, all residents are expected to contribute to the team effort of the OB care of our patients. It is simply unreasonable to expect an individual resident, regardless of their own intent to ultimately practice OB, to have greater than ten (10) active prenatal patients for whom they are solely responsible at any one given time.

In the event that you are unable to provide continuity OB care to your patients, for whatever reason, appropriate coverage must be arranged.
POLICIES
CRITICAL CARE CONSULTS

All residents must be taught skills in the care of critically ill patients. The program must document that during the three years of training, each resident has managed a substantial portion of the care for at least 15 critically ill patients.

ACGME Program Requirements for Family Medicine, IV.A.5.b.1.b.iii

Second year residents are to acquire the skills needed to manage critically ill patients on the Family Medicine Inpatient Service as well as on the critical care rotations. In determining whether or not a patient is considered critical, thus requiring a critical care consult, the following guidelines will be followed:

3100 - ICU Patients
All Family Medicine patients admitted to the 3100 - ICU will be defined as critically ill and require an ICU Consult unless:
1. The patient is admitted to the ICU primarily because of having Cardiac Surgery.
2. The patient has orders written for transfer out of the ICU within 24 hours of ICU admission.

4100 - CCU Patients
Patients admitted to 4100 - CCU are defined as critically ill if they meet one of the seven characteristics below:
1. Respiratory Failure (either)
   a. Intubated
   b. BiPAP (excluding patients on home BiPAP for sleep apnea on stable setting)
   c. Severe hypoxemia (PaO2<60 mm Hg or O2 Sat < 90% on supplemental O2), or hypercapnia PaCO2 > 50 mmHg
2. Hemodynamic instability at significant risk for respiratory compromise
3. Severe encephalopathy, delirium, or active seizures
4. Significant hyperglycemia in the critically ill patient
5. Gastrointestinal bleeding at significant risk of aspiration
6. Severe metabolic or electrolyte disorder in the critically ill patient
7. Sepsis syndrome

When Pulmonary/Critical Care is consulted on 4100, the following procedure will be followed:
1. The Pulmonary/Critical Care Division will provide the co-management through consultation of the ICU service on 3100 and through the Pulmonary consult service on 4100.
2. The Family Medicine attending will retrain all the rights and responsibilities of the attending physician for the critically ill “Yellow category” patients consulted upon by the intensivists physician.
3. Critically ill patients admitted to the ICU team for primary management “Green Category” patients will remain the responsibility of the Pulmonary Division faculty throughout their hospital stay unless the patient is accepted in transfer by another attending, following faculty –to–faculty communication.
DRESS CODE AND CELL PHONES

Dress Code

Family Medicine Residents must adhere to the standards of dress and appearance which reflect the professionalism of medicine in caring for patients.

The Department of Family Medicine residents are to wear white lab coats at all times, both in the clinic and in the hospital setting. Dress shoes, slacks and dress shirts are expected of men. Dress shoes (must cover foot), slacks/skirts and blouses are expected of women.

Scrubs may be worn after 4 pm, Monday through Friday, and all day Saturday and Sunday, for those residents on call. Scrubs may not be worn at anytime in the Family Medicine Clinic.

Family Medicine residents will adhere to the dress code of other departments when rotating through those departments.

Cell Phones

Cell phones should be used only for patient care needs while rounding or in the clinic. Please keep the cell phones on vibration when in patient care areas. Personal conversations on your cell phone while in patient care areas are not allowed.
DUTY HOURS POLICY

Duty Hours

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

2. 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.

3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

On-call Activities

1. In-house call must occur no more frequently than every third night, averaged over a four-week period.

2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

For family medicine programs, the only out-patient activity allowed is the scheduled continuity office hours in the FMC, and/or self-directed activities. No other clinical duties are permitted. FM residents may not have continuity office hours in the afternoon or evening following an overnight call responsibility. Directors are responsible for anticipatory scheduling to avoid having to cancel patient appointments for afternoon FMC continuity sessions following overnight call.

For programs using a night block rotation, residents may have their continuity office hours in the FMC either before or after the night block hours, as long as there are 10 hours of rest between assigned duties and all other duty hour rules are addressed.

Residents should also be available for critical events in the lives of their continuity patients such obstetrical delivery throughout their three years of training, but with the understanding that their subsequent schedules should be adjusted, as necessary, to comply with the duty hours restrictions.

3. No new patients may be accepted after 24 hours of continuous duty.

Patients seen post call during a morning continuity session in the FMC are not considered new patients.

4. At-home call (or pager call)

The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

ACGME Program Requirements for Family Medicine, VI, D

Department of Family Medicine Policy

In order to be in compliance with the duty hour policy, the Department of Family Medicine has mandated the following changes effective May 1, 2005:

1. All residents on the inpatient service must begin their duty shift no later than 7:00 am. Checkout each day will be at 4:00 pm., with all admissions going to the on-call resident after 3:30 pm.

2. Rounds will begin at 8:30 am each day in the conference room.

3. Any Family Medicine inpatient service resident on-call the night before will be dismissed after rounds are over and a thorough check-out has been completed. Ordinarily, post-call residents leave the hospital at noon. He/she must leave the department at that time and forward all pages to the on-call pager. No pages may be answered after the resident leaves the department when post-call.

4. The Night Supervisor must leave their rotations by noon the following day. If they began their work shift the previous day before 6:00 am, they are to notify the Program Director before the shift is over that they have begun the shift early and will need to leave their rotation early. Verification that the shift was begun before 6:00 am will be requested.

5. All duty hours must be registered daily in New Innovations. There will be weekly checks of the duty hour logs to ensure compliance. Falsification of duty hours or not registering duty hours weekly will result in disciplinary action up to and including termination from the program.

6. If a resident is asked to work beyond the 30-hour work shift or 80-hour work week on any service, the resident must inform the Program Director immediately.

7. When a resident is post-call, their pager number is to be transferred to the on-call pager by the post-call resident. In the event a resident’s OB continuity patient is admitted in labor, the on-call resident will manage the patient until the continuity resident is able to resume care the following morning.
HARRASSMENT AND DISCRIMINATION

Creighton University School of Medicine desires to foster a campus community where people can work and learn with respect, dignity, and freedom from discrimination. Individuals deserve to be free from the threat or actuality of physical violence or verbal abuse. Especially intolerable, in view of the University’s commitment to respect for the person, are offenses against persons because of their race, religion, ethnicity, physical disability, gender or sexual orientation.

Actions or expressions which may cause violent situations, create a clear and present danger of violent situations, or which represent a malicious or willful attempt to demean, degrade, or harass members of the University community or affiliated hospital settings will not be tolerated. Such actions include, but are not limited to acts of violence, physical or verbal threats, verbal harassment, slurs, degrading humor, written materials such as epithets, graffiti, or other similar expressions.

Persons who believe themselves to be victims of such actions are encouraged to report the incident to the Associate Dean for Student Affairs (280-2905) or other appropriate School of Medicine or University official. Violation of this policy will result in disciplinary action.

It is noted that residents and fellows are also student employees of Creighton University and may also be subject to abuse by faculty and others in authority. Any complaint in regard to house staff abuse may be submitted in accordance with the Graduate Medical Education (GME) policy on Grievance and will be processed accordingly.
IMPAIRED PHYSICIAN POLICY

“The Sponsoring Institution must have written policies that describe how it will address physician impairment, including that due to substance abuse.”

ACGME Common Program Requirements, II, D, 4, I

All House Staff Physicians are student employees of Creighton University and thus are subject to University Drug Free Policy on Drug-Free Schools and Communities Act Amendments of 1989.

In addition, all House Staff Physicians are subject to the Drug Abuse policies of Creighton University Medical Center and all affiliated hospitals in which they are located for training.

Since these policies mainly address conduct and the legal consequences, the following policy of the Graduate Medical Education Committee addresses the more specific rehabilitation needs of the House Staff Physicians in training. This policy does not supplant policies of the University or Affiliated Hospitals.

Any faculty member, staff member or House Staff Physician who suspects that a House Staff Physician is impaired from alcohol or substance abuse, or from physical or mental health problems should report their concerns to the Program Director, Chair of the Department or the Graduate Medical Education Office.

The Program Director of the “impaired physician” will initiate an investigation of the facts concerning the alleged impairment. The Program Director may summarily suspend the House Staff Physician if patient safety is a concern.

The Program Director and Chair will confront the House Staff Physician with the facts of the alleged problem or incident and recommend appropriate intervention. The appropriate treatment will be at the discretion of the Chair of the Department in consultation with other professionals. The Graduate Medical Education Office will be notified of the problem and recommended solution. If intensive therapy is required, the House Staff Physician may be placed on leave until it is determined that he/she is ready to return to regular duties. During this designated leave, the House Staff Physician may use sick, vacation, or time-off without pay. An agreement with the House Staff Physician in the form of a written contract in order that appropriate disciplinary measures may be initiated if the House Staff Physician does not comply with the terms of the contract. The written contract will be between the House Staff Physician and his/her program, with a copy forwarded to the Graduate Medical Education Office. Reinstatement to previous status shall be accompanied by a letter to the Associate Dean for Graduate Medical Education attesting that the House Staff Physician's physical or mental performance is no longer impaired.

Realistic goals and expectations should be established and given to the House Staff Physician in written format. A time schedule should be implemented and the progress of the House Staff Physician should be noted on a regular basis.

The House Staff Physician may receive counseling, education, and treatment through the Creighton Health Benefits Plan, Employee Assistance Program, or the Creighton Counseling Service Department. All costs not covered by the Creighton Health or Disability Plans will be the responsibility of the House Staff Physician.

The goal is to rehabilitate the House Staff Physician to a functional level as expeditiously as possible. If the House Staff Physician does not meet the stated goals he/she will be dismissed from the program. Appeal and due process is available to the House Staff Physician in accordance with the Due Process section of the House Staff handbook.
INCLEMENT WEATHER POLICY

In the event of inclement weather, Creighton Medical Associate (CMA) must maintain adequate staffing to provide quality patient care, even though Creighton University has announced an official closing. If weather is severe enough to warrant closure of CMA clinics, a specific announcement will be made through the Creighton University weather hotline. In addition, the University will use its web page to communicate weather closing information.

All employees will assume the University is open during inclement weather. To determine if the University has made a decision to close, an employee must call the Creighton University Weather Hotline at 280-5800 or use the University’s web page. Employees should not rely solely on the news media.

On rare occasions, a decision may be made to close the clinics for CMA. When that decision is made the University’s weather hotline and web page will be updated as to the closure of CMA clinics.

_in case of inclement weather those residents assigned to inpatient rotations are to report to duty regardless of whether or not Creighton University is closed._

Residents assigned to an outpatient rotation or continuity clinic are to report to duty as normal unless clinics have been closed. Residents need to call the Creighton weather line at 280-5800 for up-to-date information. Clinic closings may (or may not) be posted on television stations.
LEAVE POLICIES

Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one (1) month per academic year.

Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of the G-2 year and first month of the G-3 year in sequence) and a resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time.

Time away from the residency program for educational purposes, such as workshops or continuing medical education activities, are not counted in the general limitation on absences but should not exceed 5 days annually.

American Board of Family Medicine

The Department of Family Medicine grants the following time off from the Residency Program effective July 1, 2008:

- Vacation Time: 20 days
- Sick Leave: 30 days
- Continuing Medical Education: 5 (2nd and 3rd year residents only)
- Holidays: 7 days

The American Board of Family Practice mandates that a resident shall not be absent from the program for more than a total of 30 days in any one academic year. This 30-day total is a combination of vacation time and sick time. It does not include holiday time or CME time. Any days missed in excess of the 30 days allowed are to be made up at the end of the resident’s current PG year. The resident shall not progress to the next PGY level or graduate from the program until these days are made up.

To request a leave from the Department
All leave requests must be submitted by the 5th day prior to the month in which a leave is requested.

Those already scheduled for call must make arrangements to change call before submitting the request. It is the responsibility of the resident requesting time off to arrange this, not the chief resident.

Leave request forms are found on New Innovations. You will need to download the form and obtain the following signatures in their assigned order:

- Residency Coordinator (to determine if a resident has sufficient days of leave left)
- Rotation Supervisor
- Chief Resident (to determine if the resident is on call during the leave).
- The Program Director

A leave is not formally granted until the program director has signed off on it and the leave is listed on New Innovations.

Any time taken off without prior proper notification and approval will result in time off without pay or benefits. An unexcused absence of three days during residency will result in immediate termination from the program.
Adoption / Foster Care Leave

Adoption/foster care leave is allowed in accordance with the University's family medical leave (“FMLA”) policy. FMLA leave is without pay. House staff physicians taking adoption/foster care leave must substitute appropriate paid leave (vacation) for at least three weeks of the 12 week period. Five vacation days (one week) may be preserved and used at any time during the year in accordance with the vacation policy.

Disability Leave

House staff physicians who elect to utilize Long Term Disability are eligible to apply for benefits if a personal illness extends beyond 30 calendar days. Sick leave must be used during the 30 day elimination period. Disability leave requires physician verification.

Continuing Medical Education Leave (CME)

Second and third year residents are provided with five days of educational leave each year. This time is in addition to the vacation allotment of 20 days. Those requesting CME time off must submit a copy of the registration confirmation for the event in which they are attending.

Family Medicine Residents are granted a total of $800 per year to be used for reimbursement for conference registration, travel, and other expenses incurred in attending an educational conference or to continue their professional development. Receipts must be submitted within 60 days for reimbursement.

According to IRS regulations, any requests for reimbursement for CME monies submitted more than 60 days past the date the expense is incurred will be unpaid.

Family Medical Leave

Creighton University recognizes that serious health conditions may occur which affect the house staff physician and/or their immediate family members. Immediate family includes: spouse, son, daughter, mother or father (does not include “in-laws”). In addition, the University recognizes the importance of bonding with children, especially within the first year after birth or adoption. To accommodate these situations, the University has implemented a family medical leave (“FMLA”) policy. The provisions of the University’s FMLA policy conform to the requirements of the Family Medical Leave Act of 1993. Eligible house staff physicians are entitled to a total of 12 work weeks of leave during any 12 month period for birth, adoption/foster care, family illness and employee illness. Contact the Human Resources Department for specific details on eligibility for FMLA leave. House staff physicians in their first year of postgraduate training are not “eligible employees” under the FMLA policy and therefore are not eligible for FMLA leave.

Funeral Leave and Personal Day(s)

The University allows up to three paid days for attending the funeral of an immediate family member. Members of the immediate family are defined as father, mother, spouse, son, daughter, brother, sister, grandparents, grandchildren, or in-laws of the same degree. This paid time is NOT sick or vacation time, but in addition to other paid leave. Documentation of death may be requested.
Holidays

Effective July 1, 2008, the following holidays are granted to Family Medicine Residents:

- Independence Day (July 4, 2008)
- Labor Day (September 1, 2008)
- Thanksgiving Day (November 27, 2008)
- Christmas Day (December 25, 2008)
- New Year's Day (January 1, 2009)
- Easter Sunday (March 23, 2009)
- Memorial Day (May 25, 2009)

Residents who are scheduled for call on those days (not post-call) are permitted to substitute their holiday time at a later date. Normal FM vacation policy applies to holiday time that is carried over (i.e., only five days of any kind of leave permitted per month).

Jury Duty Leave

Any house staff physician who receives a summons and plans to report for jury duty must notify their program director as soon as possible. The house staff is encouraged to request that he/she be excused from jury duty because of their unique training status. Residents in training are generally granted this request if the request is made for postponement to the end of the training program.

The University will pay the difference between regular wages and the compensation received for jury duty, other than expenses reimbursed by the court (travel, meals, etc.), upon presentation to the Graduate Medical Education Office of the compensation received from the court.

Leave of Absence

Leave of absence may be granted at the discretion of the Chair and Program Director. Prior approval must be obtained before a leave of absence can take place. If a house staff physician is to be absent longer than their sick days (30) (for medical illness) and/or vacation days (20), they will be on leave without pay from Creighton University at the discretion of the Departmental Chair and Program Director. During any period of leave without pay that is approved by the Department Chair and Program Director, the Department is responsible for the cost of fringe benefits provided to the house staff physician, such as Health/Vision, Dental (the house staff physician is responsible for payment of the dependents dental premium), Life (for a maximum of six months), AD&D (for a maximum of six months), EAP, Long-Term Disability (ends immediately), and Malpractice Insurances (no moonlighting will be authorized on any type of leave, with the exception of vacation). RRC and certifying board requirements mandate that excess leave time must be made up (check with Program Director).

A Leave of Absence form must be completed. A Leave of Absence request form can be obtained by contacting the Graduate Medical Education Office, 280-4677.

Maternity Leave

Maternity leave is allowed in accordance with the University's FMLA policy. FMLA leave is without pay. However, a resident must first substitute appropriate paid leave (sick and vacation) for part of the 12 week period. A resident may elect to preserve five sick days and five vacation days (one week), which may be taken at any time during the year, in accordance with the sick leave and vacation leave policies.

If use of Long-Term Disability benefits is desired, the mother must first use the 30 sick days. RRC and certifying board requirements mandate that excess leave time must be made up.
A FMLA leave of absence form must be completed and can be obtained by contacting the Creighton University Human Resources Office at 280-2709.

As a recommendation and not a requirement, the recommended allotment of time-off for a normal birth should not exceed six weeks or eight weeks for a cesarean birth.

**Paternity Leave**

Paternity leave is allowed in accordance with the University’s FMLA policy. FMLA leave is without pay. A resident taking paternity leave must use three sick days and paid vacation leave for the first part of the 12 week period. Five vacation days may be preserved to be used at a later date, in accordance with the vacation policy. RRC and certifying board requirements mandate that excess leave time must be made up.

A FMLA leave of absence form must be completed and can be obtained by contacting the Creighton University Human Resources Office, 280-2709.

**Prorated Leave Time**

In the event that a resident is working less than a full 12 month calendar year (based on the July 1-June 30 schedule), vacation time, sick time, and CME time will be prorated based on the number of days/months the resident is under employment by the University.

**Sick Leave**

The University, through agreements with the affiliated hospitals, will insure that the salary provided in the contract will continue to be paid up to a maximum of 30 days per year (to include 22 week days and 4 weekends). Paid sick leave may be taken for the following reasons: (1) personal illness; (2) illness of a member of the house staff physician’s immediate family when the house staff physician’s presence and assistance is necessary in an emergency situation. Sick leave may be taken for spouse, children, and parents (including parents-in-law). The house staff physician should return to work when the crisis or emergency has passed; (3) medical and dental appointments for yourself or to accompany dependent children or spouse when your presence is necessary.

House staff are eligible to apply for long-term disability benefits if a personal illness extends beyond 30 calendar days. Sick leave for house staff physicians who are employed for less than one academic year (July-June) will be prorated for that academic year. Unused sick leave may not be accrued. In addition, unused sick leave hours are not payable at the time of separation from service. For each five (5) weekdays of sick leave (whether consecutive or nonconsecutive) one weekend will be deducted. Continued use of Friday or Monday as individual sick days will be considered as an abuse of the sick leave policy.

Sick leave is calculated on an academic calendar (July-June). Sick leave for individuals commencing or completing off-cycle will be prorated.

**Time Off With Pay**

During a leave of absence approved by the program, the program is responsible for the cost of benefits.

During FMLA, the cost of the benefits for any time off without pay will be the responsibility of the program. The house staff physician will be responsible for payment of the dependent(s) dental premium.

**Vacation**

All house staff physicians are eligible for 20 days of vacation annually. Vacation time must be approved in advance by the program director. House staff must submit appropriate vacation request forms as early as
possible. House staff should check with their respective department as to specific guidelines in which vacation must be taken. The same rules apply to house staff rotating on other services in regards to requesting time-off.

Ordinarily, house staff physicians who are on yearly contracts will not be allowed to accumulate vacation time. In rare circumstances, up to one week may be considered at the request of the Program Director, for example if the house staff physician was unable to take vacation because of an unexpected program need for the house staff physician to be present for duty. The final approval must come from the Chair of the Graduate Medical Education Committee. Unused vacation time will not be paid at the time of separation from service.

Vacation time is calculated on an academic calendar (July-June). Vacation time for individuals commencing or completing off-cycle will be prorated.

**Vacation Policy for Department of Family Medicine**

Residents are allowed to take vacation only during months on the program requirements in which a “V” is indicated.

Due to the duty hour policy and need for adequate coverage, we are not able to accommodate requests for more than 5 days vacation time in a given month. The only exception to this rule is the Surgery Outpatient Rotation for the academic year 2008-2009. You may take 10 days of leave (including holiday) during this rotation. However, five additional days immediately preceding or following this time will not be allowed.

Vacation is allowed during the FM Inpatient months provided there are five (5) residents on primary call. Due to occasional changes in resident complement, vacation requests for Family Medicine inpatient months will be considered no more than three months in advance.

*Requests for leave will not be considered after the 5th day of the month PRIOR to the month in which the leave will actually take place.*

Vacation requests are only allowed for senior residents for the time period of June 21 to June 30.

Due to the need to maintain the continuity clinics, vacation requests may be denied in order to provide adequate coverage of the clinic at all times.

**Vacation Policy for Internal Medicine Rotations**

Residents from Family Medicine who are rotating on Internal Medicine services are entitled to one (1) week vacation (five [5] working days, Monday through Friday, plus one weekend) coordinated with the Chief Resident of Internal Medicine. The exception to this is the ICU rotation in which no vacation is allowed.

Two forms must be filled out and approved prior to a vacation being granted.

(1) Department of Internal Medicine Resident Leave Request Form must be completed and signed by the designated individuals on the form and approved by the Internal Medicine Chief Resident assigned to approving resident leave. Leave requests must be submitted 60 days in advance of the desired vacation.

(2) Department of Family Medicine Resident Leave Request Form must be completed and signed by the designated individuals and approved by both the Family Medicine Chief Resident and Program Director. Leave requests must be submitted by the 5th day of the month PRIOR to the month in which the leave will actually take place.
Vacation Policy for Surgery Inpatient Rotation

Any request for time off must be requested in writing to the Surgery Program Coordinator for approval by the Surgery Program Director.

Vacation requests must be submitted in writing to the Surgery Program Coordinator by August 15, 2007.

Vacations are subject to approval by the Surgery Program Director, Surgery supervising faculty and Surgery Chief Resident preparing the schedule.

Vacations are granted and scheduled on a first come, first served basis; no exceptions.

Two residents may not take vacation at the same time on the same service.

Two resident vacations may not have overlapping weekends if they are on the same service or if they take the same weekend call.

Blackout Dates

July 1 thru July 15
December 22 thru January 2 – coverage arranged by Surgery Chiefs
June 15 thru June 30

Residents may alter their vacation dates with the approval of the Surgery Program Director, supervising Surgery faculty, and the Surgery Chief Resident preparing the schedule so long as the change does not conflict with another approved vacation.

Vacation changes will not be permitted once the call schedule for a given month is finalized and ready for distribution.
MEDICAL RECORD SUSPENSION POLICY

H&Ps, consult notes, and discharge summaries must be dictated within 24 hours of admission and discharge, respectively.

If a resident has an outstanding medical record the following procedure will be activated:

1. Each month warning letters will be sent to physicians as a reminder that they need to correct these deficiencies. If the record remains incomplete for seven days after notice the suspension sequence is activated.

2. The House Staff will be informed of any suspension and the Program Educational Coordinator will be notified.

3. The Program Educational Coordinator will contact the House Staff and inform them of the record deficiencies for both warning and suspension notices.

4. The Program Educational Coordinator will be responsible for keeping track of suspension(s) and the resulting loss of vacation days.

5. House staff who will be unavailable for any length of time (i.e., sick, vacation, educational leave, etc) must notify the Health Information Department prior to the time of absence. The Health Information Department is authorized to allow exceptions within their guidelines for such absence.

6. For each time the House Staff appears on the suspension list, the House Staff will lose one day of vacation.

7. If the House Staff is suspended and has utilized all of his/her vacation time in a given year, salary will be withheld for each day for which vacation would have been utilized.
Moonlighting

“The Sponsoring Institution must have a written policy that addresses moonlighting. The policy must:

(a) Specify that residents must not be required to engage in moonlighting;
(b) Require a prospective, written statement of permission from the program director that is included in the resident’s file; and,
(c) State that the residents’ performance will be monitored for the effect of these activities and that adverse effects may lead to withdrawal of permission. Sponsoring Institutions and program directors must closely monitor all moonlighting activities.

ACGME Institutional Requirements, II, D, 4, j

“Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.”

ACGME Program Requirements for Family Medicine, VI, F.

House staff physicians in the Department of Family Medicine are not required to moonlight.

Those who wish to moonlight must have scored 500 or higher on the most recent In-Training Exam and not be under review or on probation.

Internal Moonlighting

Internal Moonlighting is defined as working for pay at CUMC or at one of the Creighton Clinics outside of an approved rotation. Hours spent with Internal Moonlighting must be documented as duty hours. Therefore, a resident may only moonlight internally on a Friday and Saturday night when not scheduled to work the following day or during vacation time.

Residents wanting to moonlight internally shall notify the Program Director and the Administrative Assistant in the Graduate Medical Education Office by completing a Moonlighting Activity Report (MAR). Failure to complete the MAR may result in dismissal from the program. House staff are required to complete the MAR on an annual basis and may obtain a copy of the current MAR from their program educational coordinator. Malpractice insurance provided by Creighton University Medical Center covers house staff while moonlighting with proper authorization in the State of Nebraska.

The house staff physician must obtain written permission from the program director which will be placed in the house staff’s file.

Residents/fellows with J1 visas are prohibited from moonlighting. House staff may not moonlight while on sick leave or while on FMLA.

External Moonlighting

External Moonlighting is defined as employment outside of Creighton’s system. Should the house staff physician choose to accept employment in a medical professional capacity during off-duty time, he/she shall notify the Program Director and the Administrative Assistant in the Graduate Medical Education Office by completing a Moonlighting Activity Report (MAR). Failure to complete the MAR may result in dismissal from the program. House staff are required to complete the MAR on an annual basis and may obtain a copy of the current MAR from their program educational coordinator. Malpractice insurance provided by Creighton University Medical Center covers house staff while moonlighting with proper authorization in the State of Nebraska. Moonlighting outside the State of Nebraska is permissible providing proper authorization is obtained. The house staff physician is responsible for obtaining their own liability coverage for moonlighting performed outside the State of Nebraska. The house staff physician may contact the Liability Carrier utilized by the University to obtain an individual policy for...
moonlighting performed outside the State of Nebraska. The house staff will not accept employment as a physician without a permanent license in the state where he/she is employed.

The house staff physician must obtain written permission from the program director which will be placed in the house staff's file.

The house staff physician shall remain free to utilize his/her off-duty time as he/she deems appropriate, so long as such activity does not interfere with the house staff physician’s obligations to the affiliated hospitals, hamper his/her effectiveness in the education program to which he/she is appointed, as determined by the Chair and/or Program Director of the particular program with which the house staff physician is affiliated. Any moonlighting hours at an institutional training site (internal moonlighting) will be added to regular duty hours and must be in compliance with the duty hours policy.

Residents/fellows with J1 visas are prohibited from moonlighting. House staff may not moonlight while on sick leave or while on FMLA.
Creighton School of Medicine believes a high quality medical education can only be obtained in an environment where students and residents have complete and unbiased access to information regarding medical devices and supplies and pharmaceuticals and where faculty demonstrate an unbiased approach to medical devices, medical supplies and pharmaceuticals. Similarly, high quality clinical care can only be maintained in an environment where clinicians and researchers are free from the influence of vendors when choosing medical devices, medical supplies and pharmaceuticals. In order to achieve such an environment, it is the School’s policy to limit medical supply and pharmaceutical vendors’ access to students, residents and faculty.

**APPLICABILITY**

The following guidelines for vendor representatives apply to all School clinics and departments and all vendor representatives selling medical devices, medical supplies and pharmaceuticals:

**PROCEDURE**

1. No drop-ins visits are allowed at Creighton clinics and departments. All vendors must have an appointment time with identified faculty and/or staff.

2. Representatives must carry proof of their appointment at all times. Any staff can ask any vendor for the proof of appointment.
   - Representatives making service calls are exempt from this provision, but are required to be escorted as provided in Procedure Section 3.
   - 3. No meetings should take place in patient care areas. Meetings may take place in conference rooms or faculty offices. Vendor representatives should be escorted from the patient or office waiting area by staff or faculty directly to the meeting room.
   - Representatives making service calls, conducting training on equipment/supplies or participating in medical procedures may be present in patient care areas, only for the duration of the service being provided and while escorted by staff or faculty.

4. Meetings where students or residents are present shall include presentation of competing products or supplies as well as a balanced presentation of information regarding generally available scientific data regarding each product or supply. Faculty responsible for such meetings are responsible for ensuring a balanced presentation occurs.

5. Vendors are required to pick up their own advertising materials after their appointments. If advertising materials or information brochures are to be left with a department or clinic, the Department Chair or Clinic Administrator must approve the use and placement of such brochures.

6. Meals for faculty, staff, students and residents may not be funded by vendors, unless through a donation to the School of Medicine with no vendor participation in selecting the department or division hosting the meal. The office of the Senior Associate Dean for Academic and Clinical Affairs is responsible for handling vendor donations for meals.

7. Faculty and staff of the School of Medicine and Creighton Medical Associates may not accept gifts, including meals, from vendors in excess of $50 per Creighton fiscal year.
   - Gifts of items primarily for the benefit of patients (e.g., textbooks, anatomical models for use in exam rooms) and not in excess of $50 may be accepted occasionally. Gifts of personal benefit to the recipient (e.g., tickets to events, music CDs, floral arrangements) shall not be accepted, regardless of value.
   - Items of minimal value may be accepted if they are primarily associated with practice (e.g., pens, notepads and similar “reminder” items with company or product logos).
• Gifts of cash or cash equivalents (e.g., unrestricted gift certificates) shall not be accepted, regardless of value.

• Gifts given in relation to a recipient's prescribing or purchasing practices or other business with the vendor shall not be accepted, regardless of value.

• Social meals shall not be accepted. Meals that accompany a scientific or educational communication may be accepted occasionally so long as the meal is modest as judged by local standards, is offered in a venue and manner conducive to provide scientific or educational value and does not include the recipient's spouse or other guests. Representatives may not drop off meals to be eaten without the representative being present.

8. Any violation of the policy by a vendor representative can result in a suspension of vendor visitation rights to all Creighton clinics and departments for a period of 1 year.

9. Violations of this policy by Creighton staff or faculty shall be subject to applicable CU disciplinary policy.
RESIDENT FILES

The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

ACGME Program Requirements for Family Medicine V.A.1.c.

Resident files are maintained by the Residency Education Coordinator and are the permanent property of the Department of Family Medicine.

The only individuals/groups that have access to the files are:

- The individual resident for his/her own file
- The Department Chairman
- The Program Director
- The Residency Education Coordinator
- The Faculty Advisor
- The Advancement Committee when a resident is under review or on probation
- The Graduate Medical Education Office
- The RRC Site Visitor

All other requests for access to a residents file, unless subpoenaed, will not be granted without the expressed written permission of the resident whose file is being requested.
PROCEDURES and ADMINISTRATION
CHIEF RESIDENT

Each academic year a senior resident is appointed by the Program Director, after consultation with the faculty, to serve as Chief Resident. The duties of the Chief Resident are many and varied. Primary among these are being a leader, a motivator, and a role model for the other residents.

The Chief Resident is typically a third-year resident who begins his/her PGY-3 on July 1 and completes residency on the following June 30 of the academic year. There is some minor variability in this requirement. However, choosing a Chief Resident who is significantly off the typical July to June schedule would typically be avoided.

The main duties of the Chief Resident are to serve as an interface between faculty and residents, provide leadership and guidance to the other residents, represent the Program and the Department at the House Staff level, serve as an ambassador of the Program to other residency programs and students, and performing administrative responsibilities as delegated by the Program Director.

More specific duties include:
- prepare the annual call schedule for residents,
- assist with resident orientation,
- attend department faculty meetings on a monthly basis,
- attend monthly GMEC meetings,
- attend monthly Chief Resident meetings,
- attend monthly clinic meetings,
- resolve interdepartmental conflicts and concerns,
- plan and executing resident meetings, including preparing an agenda, and
- assist in interviewing and recruiting prospective resident candidates.

The newly-appointed Chief Resident will begin a transition phase by assuming many of the duties and responsibilities of Chief Resident in April of the academic year. He/she will officially take over as chief resident on June 1.

To help prepare the resident to be chief resident, the Department of Family Medicine will send the newly appointed chief resident to the AAFP Chief Resident Leadership Conference in Kansas City in May of his/her second year of training, and to the follow up meeting at the Scientific Assembly in September of his/her third year of training.

The chief resident is compensated by having meal privileges in the physician lounge.
COMMITTEES

The Sponsoring Institution must ensure that residents:
a) Participate on committees and councils whose actions affect their education and/or
patient care; and,
b) Participate in an educational program regarding physician impairment, including
substance abuse and sleep deprivation.

ACGME Institutional Requirements, II.E.2.a

Each of the third year residents are expected to serve on a committee within the hospital or within the
Department. Common committees include:

**Creighton University Medical Center**

Anticoagulant Management Committee (monthly, 2nd Monday, 12:00 noon)
Coordinator: Tammy Burns 449-4571

Credentials Committee (monthly, last Tuesday, 7:30 am)
Coordinator: Nan Tiedeman 449-5016

Ethics (every other month, 2nd Tuesday, 2:00 pm)
Coordinator: Angel Thomas 449-5003

Infection Control Committee (every other month, 3rd Thursday, 11:00 am)
Coordinator: Ann Lorenzen 449-4779

Medication Safety Team (monthly, 1st Friday, 1:30 pm)
Coordinator: Deb Lee 449-4852

Nutritional Assessment (quarterly, 4th Friday, 7:30 am)
Coordinator: Sherry Adams 449-4852

Patient Education Committee (monthly, 3rd Friday, 7:30 am)
Coordinator: Pauline Adams 449-4275

Pharmacy and Therapeutics Committee (monthly, 2nd Friday, 7:00 am)
Coordinator: Deb Lee 449-4565

Physician Satisfaction (quarterly, 3rd Wednesday, 7:30 am)
Coordinator: Nan Tiedeman 449-4998

Quality Council (monthly, 2nd Tuesday, 7:30 am)
Coordinator: Cathy Jesus 449-5374

Utilization Review Committee

**Creighton University**

Graduate Medical Education Committee (monthly, second Friday, 7:00)
Chief Resident Only

Patient Safety Committee (CUMC)

Quality Assurance Committee (CUMC)
**Department of Family Medicine**

Advancement Committee (monthly, first Friday, 8:00)  
Chief Resident Only

Education Committee (monthly, first Friday, 8:00)  
Class appointment only

Scholarly Committee (Department)
COMPLIANCE TRAINING FOR RESIDENTS

All House Staff who are continuing in the residency program on July 1 of each year must complete the annual compliance training program. This is offered the third Friday of June each year to the Department of Family Medicine.

Those residents who are unable to attend must complete the training within 30 days of the presentation of the program by watching the videotape of the training and completing an on-line quiz.

Residents who do not attend the compliance training or complete the training within 30 days will not be eligible to provide patient care and will be placed on leave without pay until the training has been completed. The only exception to this policy will be for House Staff on medical leave, maternity or paternity leave. In this case, the House Staff Physician will have 30 days to complete the training after returning to Creighton University.

The Compliance Officer will provide each educational coordinator with a list of House Staff who has not attended the required University compliance training conference. These House Staff can schedule with the educational coordinator a time for viewing the videotape and completion of the requirement within the 30 day period.
COUNSELING AND PSYCHOLOGICAL SERVICES

The Sponsoring Institution should facilitate residents’ access to confidential counseling, medical, and psychological support services.

ACGME Institutional Requirements, II, D, 4, j

Counseling and psychological services are available to all Creighton University House Staff Physicians as a part of the benefits provide to the House Staff (as student employees).

In accordance with the regulations of the American’s with Disabilities Act of 1990, all information will remain confidential, at the House Staff Physician’s discretion.

A report of finds may be forwarded to the Graduate Medical Education Office with permission of the House Staff Physician. The Graduate Medical Education Office will, in turn, forward only the recommendations for accommodation to the Program Director, with written permission of the House Staff Physician.

Recommendations with supporting findings (where necessary and appropriate) will be provided to any credentialing board or agency upon request, and with permission of the House Staff Physician.
DEPARTMENT EVENTS AND AWARDS

The Department of Family Medicine sponsors two residency-related gatherings each year. The Department provides support and funding for these events in varying amounts as indicated below.

All other “social” type expenses are the responsibility of those wanting to participate in those functions; whether they are other parties or get-togethers, gifts and recognitions, awards, or thank-you of any kind.

Holiday Party

This event is held every December. All residents, faculty, administrative staff, and their families are invited to attend. The Department provides a predetermined amount of money to the faculty host to help cover the cost of beverages, room rental, etc., to be paid upon submission of receipts. Faculty and residents will be asked to bring food from their respective countries to share in this holiday celebration.

Graduation Dinner

The Department of Family Medicine sponsors a graduation supper for graduating house staff, their families, and all members of the Department of Family Medicine in mid-June.

Each year the Department of Family Medicine awards each graduating senior a certificate of completion of the Family Medicine Residency by the American Academy of Family Practice. In addition, the Department awards the following to faculty, residents and students (student awards given at hooding):

Awards to Faculty

Excellence in Scholarly Activity - Faculty
To any FM Faculty as determined by Scholarly Activity Committee and Administrator

Excellence in Teaching - Family Medicine Faculty
To any FM Faculty as determined by Graduating Residents

Excellence in Community Service
To any FM Faculty as determined by the Department Chair

Excellence in Teaching - Non Family Medicine Faculty
To any non-FM Faculty as determined by the Graduating Residents

Awards to Residents

Outstanding Resident Award
To any Graduating Resident as determined by the first and second year residents

Excellence in Mentoring
To any FM resident as determined by the FMIG

Excellence in Scholarly Activity - Residency
To any FM resident as determined by Scholarly Activity Committee and Administrator

Moskowitz - Resident award
To any Graduating Resident as determined by the Program Director and Chair

Society of Family Medicine Teaching Award
To any Graduating Resident as determined by the program Director and Chair

Award to Clinical Supportive Staff

Family Medicine Clinic Support Staff
To any Family Medicine Clinic Staff Member as determined by the residents

Award to Medical Students

Haller Award
To any Graduating FMIC Student as determined by the Program Director and Chair

Moskowitz - Student Award
To any FMIG graduating medical student as determined by the Program Director and Chair
The Society of Teachers Award, and the Simon Moskowitz Residency Award in recognition of a resident’s academic and clinical excellence within the Creighton University School of Medicine and for exemplifying the qualities and traits of the true family physician.

All resident presentations at the Graduation Ceremony must be approved by the Department of Family Medicine at least one week prior to the Graduation Ceremony.

Other Awards and Social Gatherings

Awards and social gatherings not listed above will not be covered by Department funds.

So that you are aware, the Department pays a “levy” to the Medical Dean’s Office which helps cover the cost of two major luncheons to recognize support staff. These lunches are generally held on sequential days, one that primarily recognizes the nursing support staff, and the other the administrative, clerical, front desk, and coding staff - but they may attend either day. We encourage clinics to support these events and for their support staff to attend. They are historically VERY nice events. As the Department already pays for these events, we do not provide additional funds for employee recognition on the various “special days or weeks.” Individuals are welcome to express their appreciation to their staff and co-workers as they see fit.
ELIGIBILITY AND SELECTION PROCESS OF NEW RESIDENTS

Eligibility and Selection of Residents: The Sponsoring Institution must have written policies and procedures for resident recruitment and appointment and must monitor each program for compliance. These eligibility requirements must address the following:

1. Resident eligibility: Applicants with one of the following qualifications are eligible for appointment to programs:
   a) Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
   b) Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
   c) Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
      (1) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or,
      (2) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.
   d) Graduates of medical schools outside the United States who have completed a Fifth Pathway** program provided by an LCME-accredited medical school.

2. Resident selection
   a) The Sponsoring Institution must ensure that its ACGME accredited programs select from among eligible applicants on the basis of residency program-related criteria such as their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. ACGME-accredited programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.
   b) In selecting from among qualified applicants, it is strongly suggested that the Sponsoring Institution and all of its programs participate in an organized matching program, such as the National Resident Matching Program (NRMP), where such is available.”

Eligibility Criteria

Applications will be accepted only through ERAS.

For applications to be considered, the following requirements must be met:

1. Application deadline is December 1.

2. Graduation from accredited medical school within the last two years; or either enrolled in an accredited residency program or completion of the residency within the last two years.

3. Documentation available in ERAS must include:
   - Common Application Form
   - Medical School Transcript
   - Dean's Letter
   - 3 Letters of Recommendation
   - Personal Statement
   - Curriculum Vitae

4. No more than two (2) failures on any Step of the USMLE or COMPLEX Exams.

5. ECGMG Certification is required for international medical graduates.
The Creighton University Family Medicine Residency Program will only accept J-1 Visas; we do not sponsor H1B Visas.

**Selection Process**

The Program Director, Administrator, Coordinator and Medical Director of the FMC review all applications that meet the above criteria and determine who to invite for an interview. Our interviews take place in November, December and January on pre-determined interview dates.

The interview day consists of an orientation to our department, interviews with the Program Director, Administrator, Medical Director, and two residents, a tour of the hospital, and a tour of the Family Medicine Center. Lunch is provided. Our interview questions are based on the six competencies and are modified each year.

Applicants are ranked numerically based on their interview. A review of all candidates is performed by the Program Director, Administrator, Medical Director and Coordinator prior to submitting the rank order list. At that time, we determine who to rank and in what order. The result so of the rank list are kept confidential. We do not take applicants outside of the match.

**Advanced Credit**

**Transfer from Previous Program**

The American Board of Family Medicine does not require residency programs to obtain prior approval for transfer/advanced placement of 12 months or less for residents transferring from:

- ACGME-accredited Family Practice programs
- other ACGME-accredited specialties
- American Osteopathic Association (AOA) approved programs
- Canadian programs approved by the College of Family Physicians of Canada

The Board will, however, expect written notification of transfer or advanced placement from the program. A Transfer/Advanced Placement Form is to be forwarded to the ABFM.

Transfer/advanced placement requests requiring special attention such as: requests for credit beyond the beginning of the PGY-2 year, transfer associated with the closing of a program, transfers involving hardship circumstances, and advanced placement of international training will require prior approval from the ABFM.

Transfer credit may not exceed 12 months. The amount of credit normally recognized for each curricular area is listed below.

If a program admits a physician into training at an advanced level, but the Program Director fails to notify the Board prior to the entry of the resident into the program, the Board, at its discretion, may subsequently alter the amount of credit if there is disagreement with the amount or type of credit awarded.

If it is the intention of the program to use a portion of a resident’s previous ACGME, AOA, or CFPC-accredited postgraduate education to meet residency program requirements while having the resident complete 36 months of education (e.g., applying the prior training to requirements to permit a greater amount of elective time), the program is NOT required to obtain authorization of credit from the Board.

Should a program recruit a physician for an entry level PGY-1 position and should the physician begin training at that level, the resident will be expected to complete the full residency program of 36 months regardless of the amount of prior training or the performance of the resident after entry.
Regardless of the total amount of advanced credit granted, a resident of the Creighton University Department of Family Medicine will be required to do no less than four months on the Family Medicine Inpatient Team during the first year in our residency program, then three months during each successive year.

Transfer from one accredited Family Medicine residency program to another after the beginning of the PGY-2 year will be considered only when a residency training program closes or when there is evidence of the presence of a hardship involving a resident. A hardship is defined as a medical condition or injury of an acute but temporary nature, or the existence of a threat to the integrity of the resident’s family, which impedes or prohibits the resident from making satisfactory progress toward the completion of the requirements of the residency program. In considering such transfers, the Board is concerned primarily with the requirements for continuity of care during the resident's second and third years of training as stipulated in the “Program Requirements.” All requests must demonstrate the nature and extent of the hardship.

Any change that has not been approved by the Board and is at variance with the requirement for continuity will place the resident's application for the Certification Examination in jeopardy.

The resident must provide to the Program Director written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. The Program Director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

**Advanced-Level Entry/ Interprogram Transfers: International**

Internationally trained physicians with postgraduate training outside of the U.S. or Canada may be admitted to an ACGME-accredited Family Medicine program with advanced placement. The program must write to the American Board of Family Medicine requesting credit of 12 months or less prior to the entry of the resident into training.

Under no circumstances will transfer credit in excess of 12 calendar months be awarded, and such credit, if any, will be restricted to the PGY-1 year of residency training in Family Practice. The Board may award credit only for experiences which are equivalent to training in Family Practice and only in the amount compatible with the “Program Requirements for Residency Education in Family Medicine.”

The physician under consideration must have completed a minimum of three years of international graduate medical education beyond the receipt of the M.D. degree to be considered for any credit.

A request for transfer credit submitted by a residency program must include verifiable supporting documentation, including:

- Licensure in the state, province, and/or country of practice
- The medical school diploma (World Health Organization approved)
- Documentation of internship and residency training or equivalent including a description of the clinical rotation schedule or the number of months of specialty training completed
- Specialty and subspecialty certification
- Receipt of a valid Standard Certification from the Educational Commission for Foreign - Medical Graduates, or documentation of successful completion of a bona fide Fifth -Pathway Program or demonstration of compliance with other ACGME requirements for entry into graduate medical education in the United States

The Board reserves the right to limit the duration of the authorization of credit should the resident fail to enter training at the expected time.
Credit for Rotation

Credit for a rotation is granted upon receipt of a satisfactory evaluation from the service on which the resident rotated. In the event a resident receives an overall unsatisfactory evaluation from any rotation, the resident will not be granted credit for that rotation and will thus be required to satisfactorily make up for any unsatisfactory work.

Time required to make up for an unsatisfactory performance on a rotation may ultimately extend a resident's length of training. Salary support for time beyond 36 months is not guaranteed.

A resident has the right to appeal an unsatisfactory rotation evaluation. The appeal should be addressed to the Department of Family Medicine no more than 30 days following documented notification of the Program Director of the unsatisfactory evaluation. The Program Director will then assemble a committee to consider the resident's appeal. The appeal committee will consist of:

1. Two faculty members (one will be the resident's faculty advisor);
2. Two residents, one of which being the Chief Resident;
3. Resident Education Coordinator;
4. Program Director.

The resident appealing the unsatisfactory evaluation may choose one of either the resident or faculty member not already predetermined. The assembled committee will consider all relevant and pertinent information. The decision to uphold or overrule the unsatisfactory evaluation will be determined by a majority vote of the two faculty members and the two resident committee members. The Program Director renders a vote only in the case of a tie vote.

A resident always retains the right to file a grievance to the GME Office should he/she feel a wrongful administrative action has occurred.

Promotion

The decision to promote a resident will be determined by the Program Director with the advice of the Advancement Committee. At each level, acceptable progress will need to be documented. Additionally, the resident must be judged competent to act with limited independence. In the PGY-3 to graduation step, the resident must be judged competent to act independently. Failure to demonstrate progress may result in a resident being placed “Under Review,” on “Probation,” or terminated.

The method of evaluation shall consist of direct observation of the resident as well as indirect observation through evaluations, correspondence between departments, and written examinations (see USMLE below). It is expected that residents will participate in all aspects of the curriculum as well as in the evaluation of educational experiences and teachers. It is further expected that residents will complete all administrative responsibilities of a resident including licensure, credentialing, etc., in a timely fashion. Failure to satisfactorily participate in all aspects of the curriculum, or to complete administrative responsibilities, jeopardizes a resident's advancement, promotion, and ultimately, graduation from the program.

USMLE Step 2

A House Staff Physician must pass Step 2 CK and Step 2 CS of the USMLE or COMLEX Exams or their equivalent (as recognized by the State of Nebraska Regulations and Licensure Agency) to advance to the Postgraduate II level. Proof must be provided to both the Department as well as to the Graduate Medical Education Office. A House Staff Physician who fails to pass Step II of the USMLE or COMLEX Exam or their equivalent by the end of the first year of postgraduate training will be dismissed from the program.
USMLE Step 3

The House Staff Physician must provide proof of passing or provide proof of taking Step 3 of the USMLE or COMLEX Exams or Part II of the Licentiate of the Medical Council of Canada Qualifying Exam (LMCC) or their equivalent during the first year of postgraduate training. Proof of passing must be provided to both the Department as well as to the Graduate Medical Education Office.

The Department of Family Medicine requires that all residents must pass USMLE Step 3 by December 31 of their second year. A resident is not allowed to schedule his/her third year rotations until we have verification of a passing score.

A House Staff Physician who fails to pass Step 3 of the USMLE or COMLEX Exams or Part II of the Licentiate of the Medical Council of Canada Qualifying Exam (LMCC) or their equivalent by the end of the second year of postgraduate training will be dismissed from the program.

Remediation

Under Review

If questions are raised regarding the adequacy or appropriateness of a house staff physician's performance, the house staff physician may be placed “under review”. “Under review” status does not of itself signify unsatisfactory performance but merely indicates that the house staff physician's performance is being more closely scrutinized. The house staff physician is placed “under review” through written notification to the house staff physician with a copy placed in the house staff physician's file. This letter should clearly define the perceived problem(s) and proposed solutions. Official follow-up by the Program Director or his/her designee must occur with written documentation within three months. At this point the “under review” status may be terminated, extended for an additional three months with a maximum period of 6 months or the house staff physician may be placed on probation. “Under review” status will not be reported to state medical boards, prospective employers, or other third parties who request information about a house staff physician’s performance, as long as the issues which led to the “under review” status have been satisfactorily resolved.

Probation

If a house staff physician’s performance is deemed to be unsatisfactory based on, but not limited to, academic performance, professional attitude, emotional stability, attention to responsibilities or other inadequacies, he or she may be placed on probation. If the program director determines that the problem(s) is severe enough, the house staff physician may be placed on probation without a period of “under review”. The house staff physician and the Office of Graduate Medical Education should be notified in writing. The letter should include the specific problem(s) in performance, what constitutes evidence that the problem(s) have been resolved, and the date by which the next performance review by the Program Director or his/her designee shall be conducted.

A review of the house staff physician's performance must occur within three months following the initiation or extension of probation. After due consideration regarding correction of the problem(s), the program may end or extend the probation or terminate the house staff physician.

If a house staff physician has been placed on probation, that fact will be reportable to state medical boards, prospective employers, or other third parties who request information about a house staff physician’s performance.

Grievance Policy

House staff physicians shall have a means to express grievance against the program and/or institution, for any disciplinary actions, or perceived abuse which may have occurred. If a house staff physician has a
grievance concerning his/her program or faculty, the grievance may be presented to the faculty advisor, program director, department chair, or the Associate Dean for Graduate Medical Education for advice or in an attempt to reach an informal resolution. If informal resolution is not possible or acceptable, the grievance may be presented in writing to the program director with copies to the Department Chair and the Associate Dean for Graduate Medical Education. A written response by the program director regarding the grievance should be provided in a timely manner (not to exceed ten [10] days). If the house staff physician is dissatisfied with the response from the program or if the house staff physician feels uncomfortable in initiating the grievance at the program level, the grievance process may be initiated or continued by the Graduate Medical Education Office. A written statement of the details of the grievance should be provided to the Chair of the Graduate Medical Education Committee (GMEC), who will attempt to resolve the grievance through direct communication with the parties involved. If the results are not satisfactory to the house staff, the Chair of the GMEC shall appoint a six member (three faculty and three house staff physicians) ad hoc committee to address the grievance and provide a recommendation to the Chair for Graduate Medical Education. The grievance Committee will follow the rules as outlined in the “Due Process” section. The house staff physician may appeal the Committee’s decision to the Dean as outlined in the “Due Process” section. The Dean’s decision is final and no further appeals will be taken therefrom.

Under no circumstances shall punitive action (direct or indirect) be taken against a resident/fellow for initiating or filing a grievance. Grievances regarding compensation, benefits, harassment, sexual harassment, hospital facilities and operations or matters other than professional activities are typically referred to the appropriate institutional authority.

**Due Process by GME**

A house staff physician who has received notice of termination or non renewal of contract or has an unresolved grievance against his/her program may request a fair hearing by the GMEC. The Chair of the Graduate Medical Education Committee (GMEC) must be informed in writing, of the intent to appeal or grievance, or to pursue an unresolved grievance This notification must take place within ten calendar days of receipt of a notice of termination or a notice of nonrenewal of contract. After this time period, the house staff physician's right to appeal is forfeited. At the time of filing a notice of appeal, or as soon thereafter as is reasonably practical, the house staff physician must file with the Chair of the GMEC a written report detailing the basis of the appeal, or grievance. Such written report shall specify the names of witnesses who are to be called by the house staff physician.

In the event of an appeal, or unresolved grievance the Chair of the GMEC shall appoint a six-member ad hoc committee (three faculty, three house staff physicians) to hear the case. At least three members of the ad hoc committee shall be members of the GMEC. The Chair will establish the date on which the case will be heard by the Committee. The house staff physician will be informed in writing by the Chair, who serves as ex officio Chair of the Hearing Committee, of the right to have an advisor/legal counsel present, and other procedures of the Hearing. If the house staff physician elects not to appear in person before the Committee, his/her responsibility for presentation of an appeal is not waived. Under these circumstances, the Committee will deliberate and act based on the evidence available at the time of the hearing. Unresolved grievances will not be heard without the house staff physician being present. Failure of the house staff physician bringing the grievance to be present will terminate the grievance unless the reason for absence is deemed appropriate by the Chair of the GMEC.

In the event of an appeal the Chair of the Department of the house staff program in which the resident/fellow is engaged shall prepare a written report for submission to the Committee outlining the University's case for termination or nonrenewal, specifically discussing the reasons which support it's decision for termination. The written report shall also identify witnesses who may possess information relevant to the appeal and identify personnel records and other written reports which the Committee may determine to be necessary or helpful in its review of the appeal. Such written report shall be delivered by the Chair of the Department to the Committee as soon as reasonably practical after the Chair of the Department has received notice of appeal but in no event later than ten working days after receipt of the request. The hearing will then be scheduled as soon as possible after receipt of the Program response, but not to exceed ten working days. A copy of this report shall be furnished to the house staff physician.
with the time and place of the hearing. In the event of a grievance hearing the person or persons against
whom the grievance is directed will be asked to prepare a written response for the GMEC. Ten working
days will be allowed for a response; with or without a written response the hearing will be scheduled as
soon as possible thereafter, but not to exceed ten working days.

At the appeal or hearing the house staff physician may present any relevant evidence that supports
his/her contention that the termination or nonrenewal was not appropriate, or evidence to support
his/her grievance, including the calling of witnesses. The committee, at its discretion, may call additional
witnesses in an attempt to thoroughly investigate the factual issues on which the appeal is based. The
Committee members may question the house staff physician and his/her witnesses. The University or
persons to whom a grievance is directed may also call witnesses who may be questioned by the
committee. The Chair of the Committee shall determine the appropriateness of witnesses who are to be
called.

Ordinarily patients will not be allowed to provide testimony in behalf of or against a resident, unless the
reason for termination or nonrenewal or the unresolved grievance is specifically based on action
involving one or more patients and the Chair of the Ad Hoc Committee determines that such testimony is
essential to the hearing.

Any advisor/legal counsel present may serve only in an advisory capacity to their constituent and may not
introduce evidence or cross-examine witnesses.

The Committee is charged with reviewing the pertinent facts of the case as presented by the house staff
physician, witnesses called by the house staff physician, the program or the Committee, and all
information available in the house staff physician's personnel file, in rendering a decision reached by
majority vote. The hearing will be recorded and, if requested, a copy of the tape will be provided at the
cost of duplication. The burden of proof of establishing reasonable cause by a preponderance of evidence
for the termination of the Agreement or for the nonrenewal of the Agreement shall rest with the
University. If it is found that the University's case for the action taken has not been established, the
Committee shall order the Agreement reinstated. The burden of proof for an unresolved grievance
hearing shall rest with the house staff bringing the grievance. If a majority decision cannot be reached by
the ad hoc committee, the Chair of the GMEC will make the final decision.

The Committee shall issue a written decision on the appeal or grievance within seven working days of the
hearing and shall deliver a copy to the house staff physician, to the Chair of the Department of the house
staff physician, to the individual or individuals to whom the grievance is directed, and to the Dean of the
School of Medicine. The house staff physician may appeal the decision of the Committee to the Dean of
the School of Medicine within five working days of receipt of the decision of the Committee. The appeal
shall be in writing and shall specify the facts and theories which the house staff physician relies upon in
his/her contention that the Committee's decision should be overruled. The Dean's decision is final and no
further appeals will be taken therefrom.

Pending the outcome of the appeal, the house staff physician shall continue to exercise the privileges of
his/her Agreement subject to the responsibilities contained therein. However, the house staff physician
may be removed from clinical assignments until an appeal is completed if the Program Director or the
Chair of the GMEC believe that the charges justify such action. Salary and benefits covering the period of
time when a house staff is still employed but not assigned to any hospital shall be the responsibility of
the Department.

Termination of Contract by Department

Gross failure to perform duties, illegal or unethical conduct, or any act done willfully or by overt neglect
which may result in harm to a patient or to the program, will constitute cause for immediate dismissal.
Termination may also occur after a period of probation with inadequate correction of identified
problem(s), as described previously (Section on "Probation").
The University may terminate the Graduate Medical Education Program Agreement of a house staff physician at any time for good cause. The term "good cause" is defined to include, but is not limited to, a demonstrated lack of aptitude, emotional stability or professionalism to successfully pursue the Program; substantial violations of the instructions or rules of the University or of any of the affiliated hospitals; failure of the house staff physician to comply with the terms of the Graduate Medical Education Program Agreement; or termination by any of the affiliated hospitals of the house staff physician's appointment to its staff.

The University's decision to terminate the Agreement for good cause shall be communicated to the house staff physician by written notice not less than fifteen days prior to the proposed termination date. The written notice shall set forth the specific reasons for the University's decision to terminate the Agreement and shall be delivered to the house staff physician by registered or certified mail. Immediate termination of patient care or clinical responsibilities may be implemented by the program director where appropriate.

The first year of postgraduate training at Creighton University will be a probationary year for all house staff physicians. If a house staff physician transfers within the University from one program to another, there would be an additional probationary year, one for each time a house staff physician changes programs. Since the first year of postgraduate training is probationary, any house staff physician may be terminated without cause at the end of the year if the program is pyramidal or if the first year is preliminary or transitional.

Except for preliminary or transitional residents or termination for a good cause, the University's nonrenewal of the Agreement shall be communicated to the house staff physician by written notice four months (120 days) prior to the termination of the Agreement. Such written notice shall set forth the specific reasons for the University's nonrenewal decision and shall be delivered to the house staff physician by registered or certified mail.

Any house staff physician who is in jeopardy of not satisfying the requirements of his/her particular specialty program or is otherwise functioning at less than a satisfactory level of competence and is, therefore, in danger of having the Agreement either terminated or not renewed shall be informed as soon as reasonably practical after such determination is made.

Within ten calendar days after receipt by a house staff physician of either notice of termination or of notice of the University's decision not to renew the Agreement (other than as decided in the probationary year), the house staff physician may appeal the termination or the nonrenewal, as the case may be, as outlined in the Due Process section of the House Staff Handbook.

It is understood that the affiliated hospitals reserve the right to terminate the privileges or appointment of the house staff physicians in accordance with their policies and procedures including, but not limited to, failure to comply with their rules and regulations or standards of patient care as set forth in their respective Medical Staff Constitutions and Bylaws. Termination of privileges or appointment at an affiliate hospital will constitute grounds for good cause termination of the program appointment.

A house staff physician may terminate the Graduate Medical Education Program Agreement in the event of a substantial breach by the University and/or by any of the affiliated hospitals of any of their agreements with the University referred to herein. If the house staff physician determines to terminate this Agreement, he/she shall provide the University with fifteen days written notice by registered or certified mail, which notice shall set forth the specific reason for the termination. The University shall have fifteen days after receipt of the notice of termination to "cure" the breach specified in the notice of termination. If the University is unable, or fails to cure the breach, the Agreement shall be terminated as of the date set forth in the notice.
Termination of Contract by Resident

A House Staff Physician who decides he or she will not continue in the Program following the end of any Term must notify the Program Director four (4) months prior to the end of the Term of their intention to leave the Program after completing the Term (the “Notice”). A House Staff Physician’s failure to give proper Notice will cause the Program to suffer damages that will be difficult to ascertain with certainty. For that reason, the parties agree as follows: if the House Staff Physician fails to give proper Notice, the House Staff Physician will owe the Program, as liquidated damages, and not as a penalty, a sum of money equal to three (3) months of the House Staff Physician’s salary (the “Liquidated Damages”). The parties agree that the Liquidated Damages represent a reasonable estimate of the damages the Program will suffer as a result of the House Staff Physician’s failure to give proper notice. The House Staff Physician agrees that the Program will withhold the final paycheck which would otherwise be payable to the House Staff Physician if the House Staff Physician fails to give the proper Notice. If the Program is not able to withhold the final paycheck, the House Staff Physician will pay the amount of three (3) month’s salary as Liquidated Damages within thirty (30) days after the last day of the Term. In the event there are extenuating circumstances which result in the House Staff Physician’s failure to give proper Notice, the House Staff Physician will have the right to take the matter before a subcommittee of the Graduate Medical Education Committee (within ten (10) business days of being informed of the imposition of the Liquidated Damages) and request a waiver of the Liquidated Damages. If Creighton University advises the House Staff Physician that it will not renew the House Staff Physician’s contract, the House Staff Physician will not owe any Liquidated Damages.

Mid-cycle Breach. As noted above, this contract is for a specified Term. If a House Staff Physician decides to leave the Program before the end of the Term or fails to report for duty for three (3) days (without notifying the Program Director), the House Staff Physician will be considered to have breached this Agreement. (Note: a mid-cycle transfer to a different program within Creighton University is also considered to be a breach of this Agreement). In the event the House Staff Physician breaches this Agreement, the Program will suffer damages that will be difficult to ascertain with certainty. For that reason, the parties agree as follows: if the House Staff Physician breaches the Agreement, for any of the reasons set out in this section, the House Staff Physician will owe the Program, as Liquidated Damages, and not as a penalty, a sum of money equal to three (3) months of the House Staff Physician’s salary (the “Liquidated Damages”). The parties agree that the Liquidated Damages represent a reasonable estimate of the damages the Program will suffer as a result of the House Staff Physician’s breach of the Agreement and mid-cycle departure. The House Staff Physician agrees that the Program will withhold the final paycheck which would otherwise be payable to the House Staff Physician, upon learning of the House Staff Physician’s breach and the House Staff Physician will pay the Program the remainder of the Liquidated Damages within thirty (30) days after his/her departure from the Program. In the event there are extenuating circumstances which necessitate the House Staff Physician’s mid-cycle departure, the House Staff Physician will have the right to take the matter before a subcommittee of the Graduate Medical Education Committee (within ten (10) business days of being informed of the imposition of the Liquidated Damages) and request a waiver of the Liquidated Damages. In the event Creighton University terminates this contract before the end of the Term, as specified in the Resident Remediation and Termination Policy, the House Staff Physician will not owe any Liquidated Damages. This Article II shall survive termination of this Agreement.
**MEDICAL LICENSE AND DEA**

**State of Nebraska License**

First year House Staff are issued a Temporary Educational Permit (TEP) license to practice medicine. House staff can work under a TEP while participating in an ACGME accredited educational program.

Upon completion of one year of postgraduate training, a United States medical graduate who has passed either National Boards, Flex, or USMLE, may apply for a permanent Nebraska License by contacting:

Health and Human Services  
Regulation and Licensure  
P.O. Box 94986,  
Lincoln, NE 68509-4986  
Phone: 402-471-2118

Foreign medical graduates are required to complete three years of postgraduate training in the United States before being eligible to apply for a permanent license in the State of Nebraska. If a foreign medical graduate obtained a permanent license in another state, and is interested in applying for a permanent license in Nebraska, they should contact the Regulation and Licensure Office to obtain information on the guidelines for Reciprocity.

Prior to the issuance of the annual House Staff contract all House Staff Physicians are required to provide the Graduate Medical Education Office with a photocopy of their unexpired license. House staff who possess a permanent license should provide a copy of the wall certificate in addition to providing a copy of the pocket license, which includes the expiration date.

**Federal DEA License**

All Family Medicine House Staff must possess a Federal DEA number. It is very important to provide a copy of the Federal DEA license to the Graduate Medical Education Office. The Graduate Medical Education Office does not provide the House Staff Physicians DEA numbers to outside sources. After October 1 of the academic year, no House Staff Physician may practice without a DEA number in the Department of Family Medicine.
The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:
- oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
- approve the selection of program faculty as appropriate;
- evaluate program faculty and approve the continued participation of program faculty based on evaluation;
- monitor resident supervision at all participating sites;
- prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
- provide each resident with documented semiannual evaluation of performance with feedback;
- ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
- provide verification of residency education for all residents, including those who leave the program prior to completion;
- implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and to that end, must:
  (1) distribute these policies and procedures to the residents and faculty;
  (2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
  (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
  (4) monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- monitor the need for and ensure the provision of backup support systems when patient care responsibilities are unusually difficult or prolonged;
  (1) Programs must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular basis.
- 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;
- be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- devote sufficient time to the residency program (i.e., at least 1400 hours per year spent in resident administration, resident teaching, resident precepting and attending duties, and exclusive of time spent in direct patient care without the presence of residents);
- have a specific time commitment to patient care to maintain his or her clinical skills; and,

ACGME Program Requirements for Family Medicine, II.A

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. This evaluation must:
- 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.

ACGME Program Requirements for Family Medicine, V.A.2
**Program Director**

The Program Director will assure compliance with all of the above stated requirements for the Family Medicine Residency Program. He/She will have one private half day clinic at the FMC, and will be available for coverage when preceptors are on vacation or rounding on the inpatient service.

Each resident will meet with the Program Director on a semiannual basis. Topics covered at the semiannual meeting include:
- Review of the average scores in each of the Six Competencies and comparison of previous scores
- Continuity Patient Visits seen in the Family Medicine Center, home visits, inpatient continuity visits, and St. Joseph Villa
- OB continuity deliveries, vaginal deliveries, c-sections
- Required procedures from New Innovations’ Procedure Log
- Number of critical care patients seen
- Other resident activity such as certifications, attendance at lectures, duty hours, moonlighting, scholarly activity
- Overall evaluation of strengths and areas of needed improvement
- Recommendations/comments from the resident
- Final comments/evaluation from the Program Director

The final semiannual evaluation will 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 SUPPORT

Programs must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular basis.

ACGME Program Requirements for Family Medicine, II.A.4.k.1

Resident support is provided by a variety of methods within our Department:

1) Faculty Advisors: The residents are all assigned a faculty advisor with whom they are required to meet on a quarterly basis. At the beginning of the year, residents are asked to fill out a needs assessment survey which is communicated to their advisor. This is then reviewed throughout the year to determine if the resident has addressed the needs presented. Faculty are also instructed to specifically ask about the resident’s well being and future plans. To help facilitate the relationship a resident has with his/her faculty member, the resident spends time with the faculty advisor in his or her clinic during the orientation month and during the senior year.

2) Support Group: The residents meet as a class on a quarterly basis with our clinical psychologist to discuss the challenges of being a resident and to offer support to each other.

3) Resident Retreat: Each year there is a resident retreat held off campus which focuses on the well-being of the resident and offers opportunity to share aspects of their lives that are not usually discussed during their training period, such as faith, sharing stories of growing up, discussing the meaning of symbols in their lives.
SUPERVISION OF RESIDENTS AND CALL RESPONSIBILITIES

Resident supervision: Monitor programs’ supervision of residents and ensure that supervision is consistent with:
   a) Provision of safe and effective patient care;
   b) Educational needs of residents;
   c) Progressive responsibility appropriate to residents’ level of education, competence, and experience; and,
   d) Other applicable Common and specialty/subspecialty specific Program Requirements

ACGME Institutional Requirements, III,B,4

Supervision of Residents

Supervision of Residents occurs at all levels of training during the three year training program. Residents are under direct supervision by the attending physicians during rounds on all services and during all clinics. During the evening hours, faculty are on call for all services and are to be called for all admissions, questions regarding the management of a patient, or a change in status of a patient. Residents admitting a patient to Labor and Delivery must inform the Family Medicine attending on call of the admission. The attending is to be present for delivery. In the event of an emergency, OB is to be consulted. There is an Obstetrician faculty member in house 24-hours a day.

Supervision of junior residents is also provided at all times by the senior residents. We have two residents in house 24-hours a day, and both residents must see all new patients admitted to the Family Medicine Service to ensure the accuracy of the history and physical of the junior resident.

Call Responsibilities

Primary Call

Residents assigned to the inpatient team are the only residents assigned to primary call for Family Medicine. The call schedule is determined in advance by the Chief Resident. Once the call schedule is on the internet, schedule changes may be made by the resident but must first be approved by the Chief Resident. This will ensure complete compliance with the Duty Hours Policy and to eliminate any conflicts with the clinic schedule.

Each resident on the inpatient team will be assigned to no more than 7 calls per month. As per the duty hour policy, when a resident is on call, the following morning he/she will leave after inpatient rounds and will forward all pages to the on-call pager. The call schedule has been arranged so residents do not have clinical responsibilities the following day.

Residents who are asked to work more than 30 hours per shift, or are approaching the 80 hour work week, are to notify Dr. Hansen prior to exceeding the Duty Hour limits.

In the event there are only four residents on primary call on a given month, residents on primary call must leave the hospital immediately after presenting on the sixth floor to avoid violating duty hour policy.

Resident Night Supervisor

1. Hours will be:  Monday-Thursday: 5 pm to 7 am
   Friday: 5 pm to approximately Noon on Saturday
   Saturday: 7 am to approximately Noon on Sunday
   Sunday: 7 am until 7 am on Monday

2. The Night Supervisor will see patients post-call on Saturdays and Sundays.
3. The monthly inpatient supervisor, or designated supervisor, will assign inpatients to the Night Supervisors for weekend rounds. The Night Supervisors on the weekends will both write notes on patients. The Night Supervisor who is post call will need to check out his/her patients after morning rounds to the next Night Supervisor in order to ensure continuity of care.

4. To avoid undue fatigue for the primary call person, the Night Supervisor will assist with admissions when the primary call person has 3 consecutive admissions at the same time. However, the Night Supervisor is responsible for being present for every admission. The Night Supervisor will primarily be assigned Obstetrical patients and newborns, while the primary call person will mostly be responsible for adult and pediatric admissions. If there are no other admissions, the primary call person will accept obstetrical and newborn admission.

5. The Night Supervisor must be notified of all admissions. The Night Supervisor must go to see the patient sometime during the admission process, do a focused exam and write a short note. The primary call person is expected to do the complete H&P and dictation and follow the patient. During the 1st month an intern is on the inpatient team the Night Supervisor will need to go with the intern for the entire admit process to help with the admission.

6. The Night Supervisor is also in charge of taking calls from Florence Clinic beginning at 4:30 pm. (Since the phones are turned off at Florence Clinic at 4:30 on weekdays, the Day Supervisor will need to carry the back-up pager at all times). Please place a copy of the log from all calls in the Chief Resident's box before you leave so that the reports can be faxed to Florence Clinic and placed in the patients’ chart. Keep the original sheet in the white book.

7. If the person on primary call is a third year resident, it is up to the resident on primary call whether or not the Night Supervisor needs to come to each admit. The Night Supervisor still needs to be notified that there is an admission and should be willing to assist when asked.

8. Night Supervisors must leave their rotation at noon on post-call days and all pages must be forwarded to the supervising resident of the service on which the resident is rotating. No pages are to be answered after 12:00 noon on past-call days.

Home Call

Due to the 80 hour week and the Inpatient Supervisor taking primary call on Friday nights, home call will be necessary for 2nd and 3rd year residents who are on outpatient rotations. This home call will be in addition to the Night Supervisory call. The number of nights per month will vary depending upon the number of residents available and the number of resident vacation days scheduled. A resident may not be on home call on two consecutive days.

Guidelines

1. Home call hours are: Monday through Friday - 5 pm to 7 am  
   Saturdays and Sundays - 7 am to 7 am

2. The resident on home call must be available to come to the hospital if needed.

3. There are no meal tickets issued for home call.

4. No duty hours are logged unless a resident is actually called in to work.

5. If a resident is unable to fulfill their call, they must notify the inpatient team supervisor immediately so that the home call person can be notified. The home call resident will fulfill the responsibilities of the resident who is unable to work.
6. The Supervisor will notify the Chief Resident that the home call resident is being called into service (or Dr. Hansen if the Chief Resident is on vacation or post-call).

7. If a resident on primary call or night supervisor misses a call, it must be made-up at a later date.

8. The home call resident should only be called in for an EMERGENCY situation (major illness, hospitalization, trauma, labor, family emergency, extreme fatigue).
WORK ENVIRONMENT

The Sponsoring Institution must ensure a healthy and safe work environment that provides for:

a) Food services: Residents must have access to appropriate food services 24 hours a day while on duty in all institutions.

b) Call rooms: Residents on call must be provided with adequate and appropriate sleeping quarters that are safe, quiet, and private.

c) Security/safety: Appropriate security and personal safety measures must be provided to residents at all locations including but not limited to: parking facilities, on-call quarters, hospital and institutional grounds, and related facilities.

ACGME Institutional Requirements, II, F, 3.

Working Environment

Patients have a right to expect a healthy, alert, responsible, and responsive physician dedicated to delivering effective and appropriate care. Each House Staff program and clinical service must assure that continuity of care is provided without requiring House Staff to work excessive hours or to fail to have required time off duty.

Lectures on Fatigue are given during Orientation so that the new residents are aware of the signs and symptoms of fatigue. In the case of extreme fatigue, burn-out, family emergencies, etc., the home-call resident will be responsible for coming in to cover for the resident needing time off. In the event of a code victory (mass casualty disaster) the home-call resident will be asked to come in and assist as needed.

The resident call rooms are located in 5409 for the primary call resident and 5408 for the supervisory resident. Keys can be found in the mailbox marked call room. Residents can expect fresh linens on the bed and in the private bathroom by 4:00 pm on the day of call. If not, they are to call housekeeping at 449-4468.

A meal allowance is provided to the primary call resident and night supervisory resident for those meals taken while on in-house call. In addition, the resident lounge on 3M has sandwiches, snacks, juice and soda 24 hours and can be accessed with the 3M key.

Security is in house at Creighton University Medical Center at all times. They can be reached at 449-4090. Security at the Family Medicine Center is via the Omaha Police if needed (911). All Family Medicine Residents are provided with a key to the clinic so access can be obtained when the clinic is closed.