RESIDENT HANDBOOK

2024 – 2025

Healthy Rural California (HRC), Inc. Psychiatry Residency Program

1905 Notre Dame Blvd Suite 200,
Chico, CA 95928
Phone: (530) 999-2629
https://healthyruralca.org/

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Welcome!

On behalf of the Healthy Rural California Psychiatry Residency Program, we are excited to welcome you to our new community psychiatry residency program! Our vision is to train residents to be excellent clinicians for underserved and diverse communities in the rural region of Northern California. Residents will become effective advocates for mental health equity, will practice trauma-informed care and will provide high quality care in a variety of interprofessional clinical settings. We strive to promote diversity, equity and inclusion for our faculty, residents and patients, as well as focusing on wellness and whole person care.

The local rural community we serve provides us with a culturally diverse patient population with a breadth of pathology, allowing residents to obtain a profound knowledge of psychiatry and evidence-based practice. Our residents will gain a strong academic background through rotations and didactics with UC Davis and the VA of Northern California in Sacramento in Year 1. After this our residents will receive a stipend to move to Butte County where their focus on rural community psychiatry will begin. They will learn how to navigate the unique challenges of mental healthcare access in a rural area through rotations with clinical sites such as: Butte County Behavioral Health, Northern Valley Indian Health, and Sutter-Yuba Behavioral Health. Our residents will also be given the latitude to choose from a variety of electives, such as: Native American mental health, addiction psychiatry, trauma informed care, and cultural psychiatry. We will provide mentorship and protected time to participate in research, quality improvement and advocacy to improve the mental health of our region.

The support, dedication and commitment of our faculty, residents, coordinator, Healthy Rural California, and the entire community contributes to building a successful community psychiatry residency program. We hope to attract residents that will appreciate the beauty and diversity of our community, and desire to stay in an area that would greatly benefit from additional high quality mental healthcare providers.

Thank you for your interest in our program!

Sincerely,

Rachel Mitchell, MD
Program Director

Donovan Wong, MD
Associate Program Director

Theodore Zwerdling, MD
Designated Institutional Official

Romy Kullar, DO
Associate Program Director

Lina Benton
Residency Coordinator

Kristy Bird MaKieve
CEO and GME Director

Program Details

Institutional Mission
Beginning in Northern California, Healthy Rural California aims to meet the public health needs of California's rural communities by closing the gap in quality, access, and equity and eliminating health disparities. We will fulfill our mission through building strong partnerships and coalitions, increasing the number and quality of physicians and other healthcare providers, and addressing rural community health needs such as mental health, opioid use disorder, and alcohol use disorder.

Program Mission
Healthy Rural California's Psychiatry Residency is committed to training residents to be excellent clinicians for underserved and diverse communities in the rural region of Northern California. Residents will become effective advocates for mental health equity, will lead trauma- informed care and will provide high quality care in a variety of interprofessional clinical settings.

Program Goals and Aims
Please see our website for the program's goals and aims within the link below:

1. Prepare residents for board certification, autonomous practice, and/or fellowship.
2. Provide technical training in various treatment modalities, including psychotherapy and psychopharmacology, and in applying evidence-based guidelines to individualized patient care using the principles of trauma-informed care.
3. Impact the knowledge and skills necessary for residents to teach patients, their families, students, and fellow physicians.
4. Develop compassionate, well-adjusted residents through an emphasis on physician wellness that nurtures resilience and self-care and encourages advocacy for themselves and their colleagues.
5. Groom leaders who value collegiality and collaborate to build relationships with patients, families, among colleagues, and within/across interdisciplinary health care teams.
6. Mentor critical thinkers who understand the relationship between research and clinical care and who practice lifelong learning throughout their careers.
7. Educate residents in health care delivery systems, health policy, and aspects of community medicine characteristic of psychiatry practice in a rural setting and provide them with opportunities to apply data-drive methodologies to improve quality and patient safety, and drive innovation within the health care system.
8. Model a commitment to the medical profession, exceptional ethical behavior, and professionalism in all situations and relationships, respecting the rights, values, needs and autonomy of all people with respect to their unique perspectives and backgrounds.
9. Address inherent bias and structural racism that has become foundational to medical care, training and research in order to mitigate its contribution to human suffering.

Accreditation

Institutional Accreditation Status
The ACGME originally accredited Healthy Rural California, Inc (referred as throughout the doc as HRC), on 7/01/2021.

Program Accreditation Status
The ACGME originally accredited the Residency Program as a 4-year program with a complement of 16 residents on February 10, 2023. Our program completed an initial site visit on 11/09/2022.

Organizational Structure

Please find our Organization Structure and Board of Directors within the link below.

https://healthyruralca.org/gme/

Program Faculty and Leadership

- Program Director: Rachel Mitchell, MD
- Associate Program Directors:
  - Romy Kullar, MD
  - Donovan Wong, MD
- Program Coordinator: Lina Benton
- Program Assistant: Susanna Garcia
- Designated Institutional Official: Ted Zwerdling, MD

Faculty

- Harkirat Saggu, MD
- Duane McWaine, MD
- Gale Beardsley, MD
- Chester Austin, MD
- Stacy Berrong, DO
- Mustafa Ammar, MD
- Alexandra Duffy, DO
- Lorin Scher, MD
- Glen Xiong, MD
- Scott Summers, MD
- Raja Jagadeesan, MD
- Shelly Mitchell, PhD
- Meekile Mason, MD
- Meryam Sheriaty, MD
- Hardeep Singh, MD
- Hallie Hogan, MD

Clinical Sites

Butte County Behavioral Health- 592 Rio Lindo Ave, Chico, CA 95926
Butte County Behavioral Health (BCBH) has been providing mental health and substance use treatment to Medi-Cal youth and adult beneficiaries in Butte County for over 55 years, serving 7,000 individuals annually. They provide a wide array of behavioral health services, including clinical outpatient services for children and adults, inpatient psychiatric care, crisis intervention, and prevention and wellness services. BCBH will serve as the primary clinical site for HRC residents.

VA Northern California Health Care System – Chico VA Medical Center, 1601 Concord Avenue, Chico 9592
The Chico VA Clinic is a part of the VA Northern California Healthcare System and is an urgent care center and medical clinic that provides a wide range of outpatient medical services including Addiction Medicine and social work.

Ampla Health – 1000 Sutter St., Yuba City, CA 95991
Ampla Health is a non-profit network of community based federally qualified health centers that offers comprehensive services in Butte, Colusa, Glenn, Sutter, Tehama and Yuba Counties. Ampla Health has 14 medical and 6 dental centers throughout Northern California.

Northern Valley Indian Health - 1280 E. Gibson Road, Woodland, CA 95776
Northern Valley Indian Health is a private, non-profit tribal corporation that seeks to reestablish health care services for Indians in northern California. Since 1971, Northern Valley Indian Health has provided medical, behavioral health, and dental services in Butte, Colusa, Glenn and Yolo counties.

Sutter-Yuba Behavioral Health - 1965 Live Oak Blvd., Yuba City, CA 95991
Sutter-Yuba Behavioral Health provides services to individuals and families that are experiencing mental health and/or substance use disorders in communities of both Sutter and Yuba counties. Sutter-Yuba Behavioral Health offers a broad range of services, such as acute psychiatric services for adults and children.

University of California (Davis) Medical Center - 2315 Stockton Blvd, Sacramento, CA 95817
University of California Davis (UC Davis) Medical Center is a 646-bed university-based teaching hospital that serves 33 different counties and 6 million residents across Northern and Central California. UC Davis brings in about 800,000 visits per year. As the region's only academic health center, UC Davis serves as an innovative care center that treats complex conditions in a variety of specialties and is committed to excellence and to the highest standards in education and medical care.

VA Northern California Health Care System – Sac.VA Medical Center, 10535 Hospital Way, Mather, CA 95655
Sacramento VA Medical Center is a part of the VA Northern California Healthcare System. It is a 60-bed teaching hospital that offers a comprehensive range of health care services include medical, surgical, primary and behavior health for Rancho Cordova County. Sacramento VA Medical Center, in a joint venture with the University of California Davis, operates General Clinic Research Center (GCRC) that seeks to advance health care for Veterans and the nation.

Academics

Training Structure
HRC Residency training is 48 months. A block rotation schedule was designed that complies with all ACGME Psychiatry Review Committee requirements. Continuity clinic experiences start in the second year and continue through fourth year. All residents are expected to complete each clinic as scheduled.

Goals and Objectives
Goals and Objectives are provided for each rotation and for the program overall. Residents are expected to review the overall goals and objectives periodically to ensure their progress throughout training. Residents are required to read goals and objectives prior to the start of the clinical experience. Goals and objectives are maintained in MedHub; they are sent to you via MedHub approximately 2 weeks prior to the start of the clinical experience.

Core Competencies
The ACGME
The Accreditation Council for Graduate Medical Education (ACGME) is the accrediting body for the residency program. The ACGME is made up of employed staff and physician review committees that establish the basic requirements for all residencies and fellowships. Each specialty has a Review Committee (RC); they determine the accreditation status at the residency and fellowship levels. Accreditation is built on the ACGME's Common program requirements and refined by the RCs in the specialty-specific program requirements. Residency education revolves around six core competencies and a list of observable behaviors called the milestones. These specialty-specific metrics allow programs to measure resident progress in the knowledge, skills and abilities required for each specialty. The core competencies are listed below, and the milestones are reviewed in the program's overall goals & objectives.

Patient Care (PC)
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Medical Knowledge (MK)
Residents must demonstrate knowledge about establishing and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Interpersonal and Communication Skills (ICS)
Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates

Professionalism (P)
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Practice-Based Learning and Improvement (PBLI)
Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self- evaluation and life-long learning. locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems (evidence-based medicine).

Systems-Based Practice (SBP)
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate.

Description of Roles

Residents
Residents are responsible for communicating significant patient care issues to the supervising faculty attending and documenting that communication in the medical record. Residents must be aware of their limitations and not attempt to provide clinical services or procedures for which they are not trained and approved to perform independently.

Residents must understand the graduated level of responsibility as described for their level of training and not practice outside of that scope. Failure to function within graduated levels of responsibility, communicate significant patient care issues to the supervising physician, or appropriately document the level of supervising physician oversight may result in corrective action, including removal from patient care duties. Residents must inform the program director when appropriate faculty member is not available.

Faculty
All patients are the direct responsibility of an attending physician. The attending faculty member is responsible for the quality of all the clinical care services provided to their patients. Accordingly, when the attending faculty member accepts a resident on the service, the attending faculty member becomes the supervising physician responsible for the supervision of the resident's patient care. Supervising physicians will direct the care of the patient and provide the appropriate level of supervision based on the complexity of care and the experience, judgment, and level of training of the resident being supervised. This responsibility is exercised by observation, consultation, and direction. Fulfillment of such responsibility requires personal involvement with each patient and each resident who is providing care as part of the training experience, with sufficient duration for the supervising physician to individually delegate authority. Supervising physicians may use their discretion in allowing or disallowing residents to perform certain procedures independently, even though a resident may be credentialed to do so. The supervising physician is expected to provide the resident with timely instruction, advice, support, and feedback. The supervising physician agrees to provide a comprehensive, written evaluation at the end of the rotation.

Faculty staff members are also responsible for determining when a resident is unable to function at a level required to provide safe, high-quality care to assigned patients and must notify the Program Director of any deficiencies in medical knowledge, patient care, interpersonal communications, systems-based practice, practice-based learning, or professionalism consistent with their level of training. In addition, the supervising faculty must have the authority to adjust duty hours as necessary to ensure that patients are not placed at risk by resident physicians who are overly fatigued, impaired, or otherwise not fit for duty.

Program Director
It is the responsibility of the Program Director to develop written guidelines governing supervision of residents and establish categories of all resident activities according to graduated levels of responsibility and appropriate levels of supervision. These guidelines will vary according to intensity of patient care responsibilities, level of experience, and educational requirements in accordance with ACGME, AMA, Joint Commission, CMS and other guidelines. The Residency Program Director defines the levels of responsibilities for each year of training by preparing a description for the types of clinical activities residents may perform and assures that these levels of responsibilities are communicated to residents, supervising physicians, and the medical staff. The Program Director establishes schedules which assign qualified faculty physicians, residents or fellows to supervise at all times and in all settings in which residents provide patient care and informs all members of the health care team of faculty members and residents currently responsible for each patient's care. The Program Director establishes guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members.

Resident Supervision
It is the residency's responsibility to provide supervision to all residents consistent with our sponsoring institution's policies under the direction of the Graduate Medical Education Committee (GMEC). The Program Director will ensure there is adequate supervision appropriate to each level of training, recognizing that graduate medical education is based on a system in which the level of resident responsibility increases with years of training. Residents will be supervised in a manner that promotes the development of progressive responsibility for patient care; progressive responsibility is assessed according to the resident's level of training, ability, and experience. The resident while on duty will have access to supervision from teaching staff, either directly or indirectly. All patient care will be supervised by faculty with privileges to perform the patient care activity and faculty schedules will be structured to provide residents with continuous supervision and consultation. Please refer to the institutional and program Supervision policies and the program's overall goals and objectives for details.

Levels of Supervision
The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

Direct Supervision- Supervising physician present with the resident and patient. PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

Indirect Supervision: Supervising physician is available to provide review of procedures/ encounters with feedback provided after care is delivered. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Committees and Programs

Graduate Medical Education Committee
The Graduate Medical Education Committee (GMEC) is the Institutional body that helps the DIO carry out HRC's responsibilities as Sponsoring Institution. They perform several functions, including approving policies, new program applications, major changes, and more. Additionally, they conduct an Annual Institutional Review (AIR) to self-monitor the institution's performance. This process includes review of program quality through reviews of surveys, reports, and other data; they also conduct special reviews of programs, when needed.

The members of the GMEC include the Program Director, Program Coordinator, faculty, practice leadership and residents. The residents are peer-selected and there is also a representative from the Resident Council who updates the committee on resident activities and concerns.

Resident Forum
The Resident Forum meets at least quarterly and advises the GMEC and the Graduate Medical Education Office on issues of interest to the resident body. The Forum elects residents to serve on the GMEC, its subcommittees, and various medical staff committees in the hospital, clinic and at affiliate institutions. The Forum reviews and advises on resident physician stipends and benefits. All residents are members of the Resident Forum and select two representatives/officers who represent the resident body as voting members of the GMEC.

Clinical Competency Committee

The Clinical Competency Committee (CCC) is an ACGME-required body of the residency. The goal of the CCC is to provide broad input to the Program Director about each resident's performance in the residency program. The CCC functions in an advisory role and meets regularly to review all completed evaluations, providing a consensus-based recommendation to the Program Director as to the standing of each resident. The CCC functions objectively and in a manner that promotes the highest levels of professionalism and confidentiality. Ultimately, the Program Director has final responsibility for each trainee's evaluation and promotion decision.

The CCC is comprised of at least three members of the program faculty and meets on a regular basis. CCC members may include physicians or non-physicians from the program and other sites who teach and evaluate the residents.

The duties of the CCC include the following: review all resident evaluations at least semi-annually; prepare a semi-annual report of milestones evaluations and advise the Program Director on the progress of each resident (including promotion, remediation, or dismissal); prepare a report summarizing the CCC's recommendations and rationale for recommending any adverse action from each meeting; and advise the Program Evaluation Committee about any evaluation issues identified during CCC meetings. The CCC considers evaluations, faculty feedback, and input from patients, peers and staff. They will submit their report to the Program Director with recommendations for commendation, formal remediation or disciplinary actions and a determination of satisfactory completion of requirements for advancement/graduation.

Program Evaluation Committee

The Program Evaluation Committee (PEC) is an ACGME-required committee that performs the program's continuous improvement process. All programs are required to assess each year's current data and create a plan for the following academic year, as described in the institutional Program Evaluation Committee.

The PEC must have at least 2 faculty (one core, one other) appointed by the Program Director and one peer-selected resident. They are to meet at least annually to review the following areas as part of the Annual Program Evaluation (APE):

- An assessment of previous year's initiatives and plan to progress.
- Resident Performance and feedback.
- Graduate Performance and feedback.
- Faculty Performance and feedback.
- Faculty development.
- Program quality, including curriculum.
- Program's efforts to recruit and retain diverse residents and faculty body that reflects our local community and desires to care for the underserved.
- Program's purpose and its alignment with the institutional mission.
- An action plan that aligns with the program's mission and aims is also a part of the Annual Program Evaluation (APE). This is based on the data review and a SWOT (strengths, weaknesses, opportunities and threats) analysis and includes 2-3 program improvement and faculty development initiatives for the upcoming year. The APE is presented to the faculty and residents by the Program Director and submitted to the DIO and Graduate Medical Education Committee each year. The APE is reviewed annually in the institution's Annual Institutional Review and presented to the Board of Directors by the DIO.

Faculty Mentor Program

Every resident (mentee) will be assigned a mentor at the start of training: however, the resident may request a change of mentor at any time. Mentees are encouraged to meet with their mentor as frequently as necessary. The main purpose of the mentor is to support the resident and help them attain the educational goals and objectives set forth by this residency program.

The mentor has the following main responsibilities:

1. Meet with the mentee regularly, at least twice per year, topics to be discussed could include:
2. Progress on rotations and at the clinic practice.
3. Timely completion of medical records, rotation evaluation forms and other duties.
4. Stresses or concerns identified by the resident, resident well-being.
5. Concerns brought forth by others, especially related to professionalism, ethics or other topics not as explicitly addressed in the rotation evaluation forms.
6. Progress on research/scholarly activity projects.
7. Plans for future electives, as applicable.
8. Plans after graduation, as applicable.
9. Any areas for improvement with concrete action plan to address those concerns,
10. Review of overall progress toward completion of residency requirements.
11. Licensing and certification requirements.
12. Make recommendations, as needed, to the Program Director regarding the resident's progress.
13. Meet with mentees as needed aside from the bi-annual meeting. Residents will encounter different issues and challenges that require more frequent meetings with mentor.
14. Be available for the resident if a crisis arises.

Resident Expectations and Services

Resident Expectations

Expectations of HRC residents include the following:

1. Provides competent, compassionate patient care.
2. Works effectively as a member of the health care team.
3. Carries out administrative responsibilities, such as dictation of discharge summaries, in a timely manner
4. Meets the educational goals of his or her specific program:
5. Adheres to the assigned schedule and must stay in compliance with ACGME duty hours.
6. Attends all required educational conferences and participate in the planning of conferences per each program's requirements.
7. Provides data on their educational experience to their program director.
8. Provides evaluations of their teachers and service rotations in a timely manner.

A Resident is also expected to:

1. Teach and mentor junior resident and medical students.
2. Consistently act with integrity and honesty.
3. Function as an effective team member.
4. Effectively manage conflict.
5. Develop life-long learning skills.
6. Participate in medical center and departmental committees as assigned.
7. Demonstrate the knowledge and skills necessary to provide care and services appropriate to the population served on the assigned unit or work area.
8. Be knowledgeable of growth and development for all patient/family cultural, linguistic, spiritual, gender, and age specific needs.
9. Be able to effectively communicate and care for patient and family as reflected in the Plan for Provision of Care.
10. Perform other duties as assigned.

Compliance Training

Periodically residents and fellows will be sent materials by the Office of GME or other HRC departments which are required as a condition of employment. These items will be distributed via email to all residents and fellows. Adherence to stated due dates is mandatory. Failure to complete this requirement by the established deadline may result in progressive disciplinary action and removal from clinical duties.

Email

Residents and fellows will be issued a Healthy Rural California email address during Orientation. Residents and fellows are expected to check their email no less than every 48 hours. All official HRC communication will be sent to the HRC email address. Failure to respond in a timely fashion to email messages may result in disciplinary action.

Healthy Rural California Policy requires email sent outside HRC containing Protected Health Information (PHI) to be encrypted in advance of the email transmission.

Onboarding Requirements

Residents will be required to provide criminal background checks, fingerprinting, vaccination records and other documentation as required for each clinical site. All employees must participate in the influenza prevention program. This includes a mandatory vaccination annually. Employees who have been granted an exemption and do not receive the current influenza vaccination must take other precautions including wearing a mask during the official influenza season as defined by each clinical sites' Infection Prevention Department. Those who qualify for exemption must wear a mask at all times while at training sites and educational sessions, with the

exception of a brief meal period, in a designated meal break area, of no more than 30 minutes. Failure to comply with this requirement will result in progressive disciplinary action including remediation, removal from clinical duties and probation.

Mailbox
Each resident and fellow are assigned a mailbox. Residents and fellows are expected to retrieve mail from the box at minimum weekly. For items of a sensitive nature and/or with patient identifiers included which the resident no longer needs, a locked shred box is available in the Office of GME.

Electives
Elective rotations are an excellent opportunity for residents to narrow their focus to a particular area of Psychiatry, gain additional training in specialties that complement Psychiatry or improve knowledge or skills required for graduation. Residents receive one to three elective experiences per year except fourth year which is primarily elective experiences. Residents should consult their mentor to ensure that any identified deficiencies can be addressed if necessary. Elective requests must be received by the program office 3 months in advance of the elective for Program Director approval. This provides adequate notice to the services, allows the block schedule to be updated, and gives the resident time to coordinate any necessary paperwork. Offsite electives will also be coordinated in such a way that avoids multiple residents away from the program. See MedHub for elective request forms.

Didactics
The didactic curriculum is an important component of your residency training, therefore there is a 75% conference attendance requirement. This will be monitored monthly and reported semi-annually. Poor attendance may result in additional reading assignments/make-up work to mitigate any potential gaps in knowledge.

The didactic curriculum is well structured to cover a broad range of clinical topics with workshops and skill building opportunities. Lectures are provided by faculty, residents, and guest lecturers. The didactic schedule will be maintained in MedHub.

Note: topics and speakers are subject to change, based on availability.

In- Training Exams
Annually residents and fellows shall take the In-Training Exams. This includes the Psychiatry Residents In-Training Examination (PRITE) and Clinical Skills Evaluations. The Program Coordinator will notify residents and fellows of the time, date and location of the exam. Residents will be informed of minimum score requirements. If the minimum score is not achieved the residents may be subject to remediation or probation.

Scholarly Activity , Research and QI projects
ACGME requires all residents to complete minimum of 2 scholarly works, one of which is a QI project.

Residents will be required to complete a Quality Improvement/Performance Improvement project prior to graduation. This project may include a literature review and summary; data collection after proper approvals are given; analysis and summary of project results. The project will culminate with a presentation of the scholarly project to faculty and peers.

Other forms of scholarly activities include research, peer review publication, authoring a chapter in a book, curriculum development projects, poster presentation and case reports presentation locally and nationally, conference lectures locally and nationally. Residents are encouraged to partner with other residents and faculty for multiple co-authored projects.

Step 3 USMLE or Level 3 COMLEX

Step 3 must be passed during the first year of training. We strongly encourage you to complete Step 3 in February during the intern year. Failing Step 3 or failure to pass the exam by the established deadline may result in one or more of the following:

- Resident physician placed on remediation.
- Resident physician placed on probation.
- Resident physician required to utilize educational stipend funds to purchase prep materials.
- Resident physician does not advance PG year or salary level

The Office of Graduate Medical Education will reimburse residents who register for the exam and successfully pass it during the PGY2 year. Proof of passing the exam is required for reimbursement. The GME Office will only reimburse the fee one time.

The GME Office cannot reimburse residents who register for, and/or take the exam, prior to enrollment in residency at Healthy Rural California. The Office of GME will reimburse for the cost of the USMLE Step 3 or COMLEX Level 3, but not both.

Residents are encouraged to schedule their vacation time around the exam. Residents will be excused from clinical duties on the day of exam, however no additional days off are provided. Requests to be off to take the exam must be submitted at minimum 30 days in advance to allow scheduling changes. Some rotations may require time off requests to be more than 30 days in advance.

Postgraduate Training License (PTL) and California Medical License
Upon enrollment in Healthy Rural California training program, all residents must apply for and receive a Postgraduate Training License (PTL) from the California Medical Board.

- Participating in a California ACGME program. The issuance of a PTL will allow residents to train without violating licensing laws in California.
    - Residents must obtain a PTL within 180 days after enrollment in the program.
    - Residents must provide the Office of GME a copy of the PTL within 3 business days of receiving it, but no later than the 180th day.
    - Residents will be reimbursed the application fee for the PTL upon receipt of the PTL.
    - Failure to obtain a PTL during the first 180 days of enrollment will result in immediate removal from clinical duties.
        - The resident will be placed on a 10 day, paid administrative leave, with no clinical duties, to allow time to obtain the PTL. Failure to provide proof of a PTL by close of business on the 10th day will result in immediate termination from the program to adhere to California law.
- California Medical License: The PTL expires 90 days after the resident has completed the 12 months of training (for US graduates) or 24 months of training for (IMGs).
    - During this 90 day period, the trainee must apply for and obtain a full, unrestricted license.
    - To be eligible for a full, unrestricted license, the applicant must:
        - Complete 36 months of training in an approved program;
        - At least 24 consecutive months must be in the same program.
        - Residents/fellows must provide the Office of GME a copy of the medical license within 3 business days of receiving it, but no later than the 90th day.
        - Residents/fellows will be reimbursed the application fee for the license upon receipt of the license if still employed by Healthy Rural California. Residents who obtain the license after employment has ended or prior to employment beginning are not eligible for reimbursement.
        - Failure to obtain a California Medical License during the 90 period will result in immediate removal from clinical duties. The resident/fellow will be placed on a 10 day, paid administrative leave, with no clinical duties, to allow time to obtain the license.

Failure to provide proof of a full, unrestricted license by close of business on the 10th day will result in immediate termination from the program to adhere to California law.
- The Office of GME does not reimburse the cost of renewing the medical license, however residents/fellows may request reimbursement through the Educational Stipend process.
- Fellows who have previously not trained in California must obtain a California Medical License prior to the start of fellowship training.

Post-Licensing Requirements
Upon receipt of the California Medical License, residents/fellows must complete the following steps and provide proof to the Office of GME:

1. Provide a copy of the license to the Coordinator
2. Register with CURES/PDMP: controlled substance database; provide proof to the Coordinator
3. Register with CMS by completing CMS8550; provide proof to the Coordinator

Drug Enforcement Administration (DEA)
Residents and fellows will be issued an institutional DEA number for use with inpatient prescriptions. Residents and fellows are not eligible to write outpatient prescriptions until which time he/she/they has obtained an individual DEA license. Residents and fellows are eligible to apply for an individual DEA license upon receipt of the California Medical License and Postgraduate Training License (PTL). The cost of the DEA license is not reimbursed by the Office of GME.

ePrescribe Access
ePrescribe privileges are granted upon the beginning of residency and fellowship. All residents and fellows begin at Status #1. The Clinical Competency Committee (CCC) for each program shall evaluate each resident and fellow at least annually to determine if the resident may progress to a new status related to ePrescribe.

- Status #1: ePrescribe privileges with attending signature required.
- Status #2: ePrescribe privileges with no attending signature required.
- Status #3: ePrescribe privileges with no attending signature, plus ECPS (controlled substances) privileges. A resident must have a DEA number to advance to this status.

Board Certification
For your reference, we have listed the requirements for the American Board of Psychiatry certification below. Your training and some graduation requirements may fulfill certain requirements. Please note, completion of residency does not guarantee board certification. You must satisfy other requirements as noted below. This is a partial list that is only for your reference and is subject to change. Refer to the American Board of Psychiatry website for full requirements and instructions.

To be Board-Certified in psychiatry a candidate must:

- Be a graduate of an accredited medical school in the United States of Canada or of an international medical school listed by the World Health Organization.
- Complete all training in either a U.S. program accredited by the ACGME or approved by the ABPN or in a Canadian program accredited by the Royal College of Physicians and Surgeons of Canada as well as meet the other requirements specified in the reciprocity agreement.
- Have an active, full unrestricted medical license in the U.S. or Canada as defined in the separate General Information and Board Policies Manual on the website. Applicants are required to update their active, full, unrestricted medical licenses in their ABPN Physician Folios account.
- Have satisfactorily completed the Board's specialized training requirements described at http://www.abpn.com
- Apply online and submit an application through ABPN Physician Folios. Required documents should be emailed or mailed.

Medical Records

Each resident and fellow are required to maintain accurate and complete patient medical records in a timely manner in accordance with published regulations at all training sites. Records should be updated and closed before the resident or fellow leaves the premises. Delinquent or tardy entries may result in suspension from the electronic medical record system and progressive disciplinary action. Site specific policies may exist and education will be provided on these policies.

Each resident and fellow shall sign all notes with his/her name, telephone extension and supervising physician. Each program may set additional requirements, including logging patient encounters in MedHub or the ACGME WebADS system.

Each resident and fellow must comply with policies related to accessing medical records. Accessing medical records outside the scope of one's job, will result in progressive discipline or immediate termination from the program. Resident and fellows, as with all employees, are not allowed to access their own medical records or the medical records of any family members or friends.

Unless approved by the Program Director, residents and fellows may not utilize the services of others to enter notes. This includes medical students, staff and scribes. Verbal orders are to be reserved for emergency situations. Routine use of verbal orders for non-emergent care shall result in progressive disciplinary action. Verbal orders must be signed within 48 hours or in accordance with clinical site policies.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated significant changes in the legal and regulatory environments governing the provision of health benefits, the delivery and payment of healthcare services, and the security and confidentiality of individually identifiable, protected health information. The law is composed of two major legislative actions: provisions for health insurance reform and requirements for administrative processes. Complying with all aspects of HIPAA has required that providers and all entities within the healthcare industry (including clinical research) comply with certain standards in information systems, operations policies and procedures, and business practices.

Reporting a Workplace Injury

All work-related injuries must be reported immediately to Human Resources, the Program Director, DIO or Director of GME. Work related injuries include, but are not limited to, needle sticks and exposures.

Sexual And Other Unlawful Harassment

HRC is committed to providing a work environment free of harassment in any form, including inappropriate and disrespectful behavior, intimidation, and other unwelcome conduct directed at an individual because of their inclusion in a protected class. Applicable federal and state law defines harassment as unwelcome behavior based on someone's inclusion in a protected class. Sometimes language or actions that were not expected to be offensive or unwelcome actually are, so employees should err on the side of being more sensitive to the feelings of their co-workers rather than less. The following are examples of harassment; behaviors not in this list may also be considered harassment:

- Unwanted sexual advances;
- Offering employment benefits in exchange for sexual favors;
- Retaliation or threats of retaliation for refusing advances or requests for favors;
- Leering, making sexual gestures or jokes, or commenting on an employee's body;
- Displaying sexually suggestive content;
- Displaying or sharing derogatory posters, photographs, or drawings;
- Making derogatory epithets, or slurs;
- Ongoing teasing about an employee's religious or cultural practices;
- Ongoing teasing about an employee's sex, sexual orientation, or gender identity;
- Physical conduct such as touching, assault, or impeding or blocking movements

Sexual harassment on the job is unlawful whether it involves coworker harassment, harassment by a manager, or harassment by persons doing business with or for HRC, such as clients, customers or vendors.

Retaliation
Any form of retaliation against someone who has expressed concern about any form of harassment, refused to partake in harassing behavior, made a harassment complaint, or cooperated in a harassment investigation, is strictly prohibited. A complaint made in good faith will under no circumstances be grounds for disciplinary action. Individuals who make complaints that they know to be false may be subject to disciplinary action, up to and including termination.

Enforcement
All managers and supervisors are responsible for:

- Implementing HRC's harassment policy;
- Ensuring that all employees they supervise have knowledge of and understand HRC Policy
- Reporting any complaints of misconduct to the designated company representative, the another company representative, so they may be investigated and resolved internally;
- Taking and/or assisting in prompt and appropriate corrective action when necessary to ensure compliance with the policy; and
- Conducting themselves in a manner consistent with the policy.

Addressing Issues Informally
Employees who witness offensive behavior in the workplace - whether directed at them or another employee - are encouraged, though not required, to immediately address it with the employee whose behavior they found offensive. An employee who is informed that their behavior is or was offensive should stop immediately and refrain from that behavior in the future, regardless of whether they agree that the behavior could have been offensive.

Harassment Complaint Procedure
Employees are encouraged to use the Complaint Procedure to report behavior that they feel is harassing, whether or not that behavior is directed at them. The Complaint Procedure provides for immediate, thorough, and objective investigation of claims of harassment. Appropriate disciplinary action will be taken against those who are determined to have engaged in harassing behavior.

Training
Employers are required by law to provide 2 hours of sexual harassment and abusive conduct prevention training to all supervisors and 1 hour of such training to nonsupervisory employees. Training is required once every 2 years and within 6 months of hire or promotion. Seasonal and temporary employees or employees hired to work less than 6 months must be trained within 30 calendar days after hire or within 100 hours worked, whichever is earlier.

Abusive Conduct
Abusive conduct means malicious conduct in the workplace that a reasonable person would find hostile or offensive and unrelated to an employer’s legitimate business interests. Abusive conduct may include repeated infliction of verbal abuse, such as the use of derogatory remarks, insults, and epithets, verbal or physical conduct that a
reasonable person would find threatening, intimidating, or humiliating, or the sabotage or undermining of a person’s work performance. A single act will generally not constitute abusive conduct, unless especially severe.

HRC considers abusive conduct in the workplace unacceptable and will not tolerate it under any circumstances. Employees should report abusive conduct to a manager or Human Resources. Managers are responsible for ensuring that employees are not subjected to abusive conduct. All reports will be treated seriously and

investigated when appropriate. Employees who are found to have engaged in abusive conduct will be subject to discipline, up to and potentially including termination. Retaliation against an employee who reports abusive conduct or verifies that it took place is strictly prohibited.

Complaint Procedure
HRC has established a procedure for a fair review of complaints related to any workplace controversy, conflict, or harassment. Employees may take their complaint directly to the person or department listed in Step 2 if the complaint is related to their supervisor or manager or if the employee feels the supervisor or manager would not provide an impartial resolution to the problem.

Step 1
The complaint should be submitted orally or in writing to a supervisor or manager within three working days of the incident or as soon as possible. Sooner is better, as it will assist in a more accurate investigation, but complaints will be taken seriously regardless of when they are reported. Generally, a meeting will be held within three business days of the employee's request, depending upon scheduling availability. Attempts will be made to resolve the issue during the meeting, but regardless of whether there is an immediate resolution, the supervisor or manager will give the employee a written summary of the meeting within three business days. Resolution may take longer if further investigation of the complaint is required. If the employee is not satisfied with the resolution, they may proceed to Step 2.

Step 2
The employee may submit an oral or written request for review of the complaint and Step 1 resolution to the another company representative or a designated investigator. This request should be made within three working days following the receipt of the Step 1 resolution. The another company representative or the designated investigator will review the complaint and resolution and may call an additional meeting to explore the problem. If warranted, additional fact-finding will be undertaken. A final decision will be rendered within 10 working days after receiving the Step 2 request, and a written summary of the resolution will be provided to the employee who filed the complaint.

Corrective Action
A high level of job performance and professionalism is expected from each employee. In the event that an employee’s job performance does not meet the standards established for the position, they violate company policies or procedures, or their behavior is otherwise unacceptable, corrective action may ensue. Corrective action may include, but is not limited to: coaching, oral or written warnings, performance improvement plans, paid or unpaid suspension, demotion, and termination. The type and order of actions taken will be at management's sole discretion and HRC is not required to take any disciplinary action before making an adverse employment decision, including termination.

Subpoena
Residents and fellows must notify the Director of Graduate Medical Education or the Director of Risk Management immediately upon being served a subpoena related to care provided during the course of enrollment in a residency program.

Transportation
Residents and fellows are required to have access to reliable transportation when needed to travel between training and education sites. Mileage is not reimbursed for travel between training locations. Exceptions to the mileage reimbursement can be made at the program level.

Resident Feedback

HRC is committed to providing a psychologically safe environment that encourages everyone to raise concerns without fear of intimidation or retaliation. In addition to promoting direct face-to-face discussions to resolve conflicts we also provide multiple avenues for reporting concerns such as inadequate supervision and accountability in a protected manner that is free from reprisal. For more information, please refer to the GME Policies in MedHub, which supersede all information in this handbook.

Formative Evaluation and Feedback

Evaluation and feedback are a critical component of residency training. It is the program's responsibility to ensure that all residents are systematically evaluated regarding their knowledge, skills, performance, professional growth, and self-care on an ongoing basis throughout their training. Evaluation tools include direct observation, performance on standardized exams, attendance, and chart audits.

The program collects and assesses the same information for each resident with an array of evaluation tools and processes that utilize and address the core competencies. Evaluations are scheduled in a consistent and timely basis over the academic year, while feedback can be provided (and requested) at any time. All evaluations, except for faculty evaluation of the residents, are confidential and the program goes further to protect the resident's identity by aggregating evaluations of the faculty so that individual evaluations are not read by the attending physician.

Evaluations are provided through MedHub and are scheduled and distributed by the residency program office.

Patient's feedback will also be considered. Patients are surveyed regarding the resident's respect, compassion, integrity, confidentiality, responsiveness to their needs, and sensitivity to their culture, age, gender, and disabilities. Evaluations will be compiled and reviewed at least twice a year by the CCC and recommendations made to the Program Director. The Program Director and the DIO will meet annually to discuss resident performance and contract renewal, taking the resident's professionalism into account.

Evaluation Forms

The following are multiple forms of evaluation the program uses through MedHub. Special conditions may require a paper form to be utilized.

FORM	COMPLETED BY	FREQUENCY
Resident evaluation of faculty	Resident	Quarterly
Resident clinical site evaluation	Resident	Monthly
Faculty evaluation of resident	Supervising Faculty	Quarterly
Peer evaluation	Resident	Semi-annually
Multi-source evaluation	Non-physician team members	Semi-annually
Semi-annual evaluation	Program director	Semi-annually
Resident evaluation of program	Resident	Annually
Faculty evaluation of program	All faculty	Annual
Final summative evaluation	Program director	Upon graduation or transfer from residency

Semi-Annual Evaluation

Semi-annual evaluations are required by the ACGME. The Program Director conducts semi-annual evaluations with the residents in December/January and May/June. The Program Director reviews all recommendations from the CCC prior to meeting the resident. Ultimately the Program Director has final say over the residents'

progress and status in the program.

The evaluation will include a review/discussion on:

- Resident's overall performance on each milestone, including aggregated evaluation data/comments
- Residents self-evaluation
- Resident's individualized learning plan and remediation status (from resident advisor, as applicable)
- Exam scores
- Conference attendance, clinic productivity and a case log review
- Duty hour compliance and medical record completion
- Patient satisfaction results, chart reviews, and shadowing
- Review of scholarly activity
- A well-being check-in

This is also an opportunity for the resident to discuss concerns, ask questions and make recommendations. After meeting with the resident, the Program Director will document the semi-annual evaluation in MedHub.

Final Summative Evaluation

A final written evaluation by the Program Director is required by the ACGME and must verify that the resident is able to "engage in autonomous practice upon completion of the program". This process will follow that of the semi-annual evaluation. The final evaluation will be kept as part of the resident's permanent file, and a copy will be given to the resident within 30 days of graduation. Future requests for copies will be fulfilled within 30 days of the receipt of the request.

Academic File

The residency program maintains a comprehensive resident record of contact information, rotations, evaluations, duty hours, scholarly activity, procedures/encounters, previous training history (including medical school), certifications (including ECFMG, if applicable), milestones achievements, records of any educational disciplinary actions and other content as determined by the Program Director and/or the Sponsoring Institution. Each resident's academic file is maintained in MedHub, a cloud-based online residency management suite that can be accessed from any internet source. Residents are encouraged to be proactive participants in their training and review all aspects of their academic file regularly.

In addition, contact information, including e-mail, phone number(s), and emergency contacts, must be maintained within the residency/fellowship management suite. This information will be verified/updated on an annual basis. Secure storage to prevent loss of records, back-up and recovery protocols are in place at the Sponsoring Institutional level. These records are available for review by the ACGME in the event of a site visit.

Renewal, Promotion, Dismissal Policy

The decision to promote or graduate a resident will be determined by the Program Director with recommendation from the Clinical Competency Committee (CCC) and the advice of the faculty. This is determined by the cumulative results of all evaluations and progressive achievement of the ACGME Milestones. The faculty's assessment of the residents' overall performance and ability to assume the responsibilities of the next level is vital in the decision for promotion. Promotion and retention are also dependent on continued appropriate moral, ethical and professional conduct of the resident.

In the event of a proposed non-renewal of the Training Agreement, the resident must be provided with a written notice of non-renewal of the Training Agreement no later than four months prior to the end of the resident's current Agreement. However, if the primary reason(s) for the non-renewal occurs within the four months prior to the end of the Agreement, HRC must ensure that its ACGME accredited programs provide the residents with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement. Please refer to program policy, "Resident Renewal, Promotion, and Dismissal" in MedHub or your contract for additional details.

Certificate of Completion
Residents shall be awarded a Certificate of Completion of Graduate Medical Education when they complete their residency training. If the resident leaves prior to the completion of 48 months of residency training, the resident will receive a Certificate of Completion indicating the number of years and months that were successfully completed.

Awarding of a Certificate of Completion is contingent upon the relevant periods of appointment having been completed to the satisfaction of the faculty of the Program, the Program Director, and the GMEC. Awarding of a Certificate of Completion will be conditioned upon the resident having, on or before the Expiration Date, returned all Medical Center property delivered to them, completed all patient and other records for which they are responsible, completed the "Exit Interview Questionnaire", as appropriate, and settled all their obligations with the GME Program, the GME Office, the Medical Center, as appropriate, including those obligations identified in the resident contract.

Resident Services

Resident Well-Being

It is recognized by the Program that residency is a time of intellectual and physical stress. It is important that residents take care of themselves, physically, emotionally, and spiritually. Residents will be encouraged to sign up with a primary care provider at the beginning of residency, but this is only one component of resident well-being. All program faculty and staff are aware of the stressful nature of residency training and are prepared to offer help in problem solving for anyone who may manifest psychiatric, economic, marital, or social difficulties.

The HRC Psychiatry Residency Program will deal with the educational needs on an individual basis for those residents with prolonged medical illness. Recommendations regarding appropriate and available counseling and/or support services will be provided. Please refer to the program's Resident Well-being policy and the GME Well-being policy, both of which are in MedHub.

Salary

Compensation will be paid to the Resident in semi-monthly installments by check or direct deposit based upon an annual rate:

PGY-1	$66,560.00
PGY-2	$68,250.00
PGY-3	$71,662.50
PGY-4	$75,245.63

Summary of Benefits
Residents are eligible for medical insurance offered through HRC's insurance. These benefits options and annual premiums are renegotiated annually. Contact the Office Manager for further information regarding the various plan options.

Insurance – paid for by Healthy Rural California

- Comprehensive health, dental and vision insurance
- Life Insurance
- Worker's Compensation

- Professional Liability Insurance

Additional Funding and Benefits

- Educational stipend: $2000 annually
- Step 3 Reimbursement
- Resident Training License Reimbursement
- Membership in one professional organization determined by the program
- Funding to present research
- Meal allowance based on clinical site
- Moving stipend for transition to PGY-2
- Certifications: ACLS, PALS, NRP, ATLS, ALSO (varies by program)
- Discounted gym membership
- Paid orientation time
- Free parking at HRC office (paid parking may still vary by clinical site)

Vacation, Sick Time and Leave of Absence

- Paid vacation time – 20 days per academic year
- Paid sick leave – 7 days per academic year
- Medical, Parental, and Caregiver leave – 6 weeks paid leave once during residency according to ACGME regulations below
- Residents who exceed the maximum number of weeks will be required to make up the time to ensure adherence to ACGME and medical board specialty requirements.

Health Insurance
Customize per your policy: Each resident must submit to HRC's human resources the health insurance enrollment form within 30 days of the appointment date. Residents can choose their insurance through Ease. Each year, the month of June is Open Enrollment. New enrollment and/or changes in coverage must be made during this period of time. Changes during any other time are only allowed for a qualifying event. Upon initial selection of coverage and enrollment, the effective date of coverage will be retroactive to the first of the month following 60 days of employment. If an employee wants to add a domestic partner or spouse or dependence, they would be responsible for premium. If dependents are acquired during the year, they may be added within 30 days of a marriage, birth, or adoption. At the time of separation from HRC, continued insurance coverage under the terms of COBRA may be elected. HRC offers medical, dental, vison and life insurance.

At HRC we strive to provide comprehensive insurance coverage options for our valued employees. HRC will contribute to an employee's medical, dental, vision and life insurance at a monthly amount or percentage that is set by management and reviewed annually. HRC complies with all applicable federal and state laws with regard to benefits administration. HRC reserves the right to change or terminate health plans or other benefits at any time.

All regular full-time employees are entitled to health insurance and other company sponsored health benefits, as may be in effect from time to time. New qualifying employees will be eligible for health insurance coverage the 1st of the month following 60 days of employment. New employees may elect not to be covered, with the permission of HRC, provided the percentage of employees not covered is within the benefit plan specifications.

HRC offers a 401(k) retirement plan. New qualifying employees are eligible to enroll the 1st of the month following 90 days of employment.

Consult the applicable plan document for all information regarding eligibility, coverage, and benefits. It is the plan document that ultimately governs your entitlement to benefits.

Continuation of Benefits

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), or a state mini-COBRA law, employees may be allowed to continue their health insurance benefits, at their own expense, for a set number of months after experiencing a qualifying event. Length of coverage may be dependent upon the qualifying event. To qualify for COBRA continuation coverage, the covered individual must experience a qualifying event that would otherwise cause them to lose group health coverage. The following are qualifying events:

For Employees
• Voluntary or involuntary termination of employment for reasons other than gross misconduct • Reduction in numbers of hours worked

For Spouses
• Loss of coverage by the employee because of one of the qualifying events listed above
• The covered employee becomes eligible for Medicare 20
• Divorce or legal separation from the covered employee
• Death of the covered employee

For Dependent Children
• Loss of coverage because of any of the qualifying events listed for spouses
• Loss of status as a dependent child under the plan rules

Employee Assistance Program
HRC provides counseling services through an Employee Assistance Program (EAP) available to all residents. Specific details about EAP are available from the Program Coordinator. All services are confidential. Residents will also learn techniques for mitigating fatigue including adequate sleep, nutrition, and exercise. The faculty will undergo the same training during faculty development sessions. University of California (Davis) Medical Center and VA Northern California Health Care System provides sleep rooms for napping and HRC provides ride share/taxi reimbursement for residents too tired to safely drive home. For additional information, refer to the Fatigue Mitigation policy in MedHub.

Disability
HRC supports and fully complies with the Americans with Disabilities Act and Amendments (ADAA) and the California Fair Employment and Housing Act (FEHA). HRC will make all reasonable efforts to accommodate qualified residents with verified disabilities by providing them with the necessary auxiliary aids and services that do not fundamentally alter the measurement of the skills or knowledge that is integral to residency training or result in an undue burden or hardship. The parties will engage in the interactive process to determine what accommodations may be necessary and reasonable under the ADA and the FEHA.

In the absence of applicable HRC policies, the program will refer to the Psychiatry Board-specific ADA Policies and Procedures if applicable with regard to special accommodations for residents with disabilities and act in accordance with the ADA, FEHA and any other applicable local, state, or federal laws and regulations.

Malpractice
HRC will provide professional liability insurance coverage for each resident for the duration of their training. Such coverage will provide legal defense and protection against awards from claims reported or filed during or after the completion of their residency training if, and only if, the alleged acts or omissions of the Resident are within the scope of training.

Healthy Rural California, Inc. will provide professional liability insurance for all duties performed by the resident while on the job. (ACGME Institutional Requirements IV.B.2.f.)

HRC shall provide the Practitioner, at HRC's expense, a malpractice liability policy under the Federal Tort Claims Act (FTCA). Such coverage is akin to a private professional liability occurrence made insurance policy with limits of One Million U.S. Dollars ($1,000,000) per occurrence, and Three Million U.S. Dollars ($3,000,000) aggregate. This coverage shall apply to all clinical outpatient services provided on-site at HRC or through arrangements provided for by HRC (e.g. home visits). No coverage is provided for services outside of the scope of HRC's practice. Those covered by FTCA are also provided "Tail" coverage under these FTCA arrangements. In addition to, and at the exclusive discretion of HRC, HRC shall obtain "wrap around" professional liability coverage through a commercial carrier for any potential gaps in FTCA coverage.

This Professional Liability Coverage Letter of Understanding shall be completed upon appointment to any HRC's GME training program.

The professional liability insurance coverage does not apply to professional activities (work or clinical services) in which the Resident becomes involved in outside of the residency program. Therefore, this coverage does not apply to moonlighting activities. However, work at affiliated or associated hospitals, clinics or elsewhere is covered when it falls under the scope of HRC residency training.

Workers Compensation
If a trainee sustains a work-related injury or illness, they are eligible to receive benefits under workers' compensation law. This program is designed to guarantee medical attention for the injury or illness and to ensure regular monetary benefits as a means of financial support while medically unable to return to work. HRC pays the premiums for this program. Information regarding workers' compensation and its activation process is available upon request from the GME Office.

Resources

Library
Library access is included through our partners at the University of California, Davis Medical School. The library has electronic resources, including computer terminals that allow residents access to online resources.

Parking
Residents and fellows are responsible for parking in appropriately marked employee spaces and provided free of charge. Residents and fellows are not permitted to park in physician parking, unless granted a parking permit from the medical staff office. Instances where a resident may be issued a medical staff parking permit include those who have gained moonlighting privileges. The office of GME is not responsible for any tickets, fines or fees to residents or fellows.

Meals
Residents on duty have access to food services at all participating hospitals. In addition, the resident call areas have refrigerators that residents can store their food in.

Call Rooms
Resident call rooms are located at each affiliated training site. The number and location of call rooms vary according to training site. It is the resident's responsibility to check with the program office for specific locations of call rooms, access codes and/or keys.

Educational Stipend
Educational materials are purchased using the resident educational stipend provided yearly ($2,000). This can include supplies, textbooks, conference expenses and other expenses related to residency training.

Residents must fill out an expense form that will be approved through the Program Director for reimbursement.

Lactation Room and Policy
Residents have the right to request lactation accommodations by notifying the Program Director, Program Coordinator or Office Manager at the clinical facility. Clinical sites should provide a reasonable amount of break time to accommodate an employee desiring to express breast milk each time the employee has need to express milk. A lactation room or location shall not be a bathroom and shall be near the employees' work area, shielded from view, and free from intrusion while the employee is expressing milk. Please refer to the Resident Services policy for additional details. Contact the GME office for a list of locations.

Resident Lounge
A resident lounge is available at the practice and partnering sites. They are reserved areas for you and your fellow residents to confer, study and relax. Contact the GME office for a list of locations

Annual Retreat
The Program Director works with the residents and faculty in planning an annual resident retreat. The retreat provides another opportunity for the residents and faculty to strengthen connections through reflection, teambuilding, and discovery. The retreat may be cancelled when circumstances that compromise safety arise.

Attendance & Time Off

Scheduling of Vacation, Leave of Absence, and Sick Leave
Trainees must follow all hospital, department, and program procedures regarding vacation and paid time off requests and documentation for any leave of absence or personal days, and, to the extent possible, must work with their program director and other applicable clinical supervisors to minimize disruption to clinical care from any vacation or non-urgent personal paid time off. Any absence due to illness, personal days or leave of absence, must be recorded appropriately in MedHub. Vacation days should be scheduled at least 30 days in advance and as close to the beginning of the academic year as possible. The Program Director and coordinator should be notified of the need for sick leave as far in advance as possible.

Holidays
Residents will follow the holiday schedule of the clinical site at which they are working during any given holiday. If residents do not have the holiday off at their clinical site, they may request to have it off using vacation days according to the needs of the clinical site.

Vacation
Each resident, regardless of their training level, is required to take 4 weeks of paid leave per year, for a maximum of 20 weekdays per year. These vacation days will be available in a lump sum at the beginning of each academic year. Vacation leave must be requested from the program regardless of which facility the resident is assigned to at the time of leave. Vacation time involving affiliate institutions must be arranged on a timely basis with the affiliating institution staff. Vacation cannot be taken during inpatient medicine and neurology rotations. Interns will schedule 2 two-week blocks through UC Davis department of psychiatry. Thereafter, vacations will be scheduled through HRC. Residents are expected to complete at least 75 percent of scheduled shifts in order to receive credit for the rotation. Therefore, a resident can only miss one week of a four-week rotation or two weeks of an eight-week rotation. Exceptions will be given on a case-by-case basis by the Program Director. Any days of vacation that have not been requested by the resident will be scheduled by the program by the end of the academic year.

Sick Leave

Each resident will receive 7 days of paid sick leave initially upon hire and at the beginning of each 12-month period. The 12-month period is based on your hire date. This benefit does not accrue and does not carry over from year to year. Sick time will be paid at the employee's regular rate of pay.

Paid sick leave may be used for the purposes described below.

- Diagnosis, care, or treatment of an existing health condition of, or preventative care for, the employee or the employee's family member.
- Leave under this policy may also be used by an employee who is a victim of domestic violence, sexual assault, or stalking to seek aid or medical attention, obtain services or counseling, or participate in safety planning.

For purposes of paid sick leave, a covered family member includes:

- A spouse, registered domestic partner, child (regardless of the child's age), parent (including a step-parent or parent-in-law), grandparent, grandchild, sibling or a designated person identified by the employee at the time the employee requests the leave.

Employees requesting time off under this policy must provide as much advance notice as possible. Where the need for paid sick leave is unforeseeable, employees must provide notice as soon as practicable.

Unused time under this policy is not paid out at the time of separation from employment. However, residents who are re-employed with the Company within a year of separation will have any unused paid sick leave accrued under this policy reinstated.

Residents are encouraged to take time off under this policy and HRC prohibits interference with any rights under this policy or retaliation against an employee for taking time off under this policy.

Leave under this policy may run concurrently with leave under local, state or federal law, including leave taken pursuant to the California Family Rights Act or the Family Medical Leave Act.

Medical, Parental and Caregiver Leave for Residents

HRC offers Medical, Parental and Caregiver Leave specifically to Residents per the requirements of the Accreditation Council for Graduate Medical Education (ACGME). This policy provides a job-protected leave, as described herein, which Residents can use when they experience a qualifying reason.

Qualifying Reasons:

1. To bond with a new child after the child's birth, adoption, or placement in foster care with the Resident ("baby bonding leave")
2. To care for a family member who has a serious health condition. For this leave reason, family members include parents, parents-in-law, children, spouses, registered domestic partners, grandparents, grandchildren, siblings or a designated person. Designated person is defined as an individual related by blood or whose association with the employee is the equivalent to a family relationship
3. For the Resident's own qualifying serious health condition that makes the Resident unable to perform their job.

Notice Requirements: Residents should provide HRC with at least 30 days advance notice of the intent to take Medical, Parental and Caregiver Leave. When this is not possible, notice should be given as soon as practical. In order to be approved for Medical, Parental and Caregiver Leave, the Resident must submit certification from a healthcare provider to confirm the Resident's need for medical leave to care for themselves or a family member.

Waiting Period: There is no waiting period for Medical, Parental and Caregiver Leave. Resident employees are eligible starting on the first day of their program.

Leave Period: Leave under this policy is available to Residents for up to a maximum 6 weeks per ACGME-accredited program. The 6 weeks may be taken intermittently as according to rules under the California Family Rights Act.

Please Note: Leave under this policy will run concurrently with FMLA, CFRA, or other leave entitlement provided in connection with the employee's need to take leave based on a qualifying reason.

Pay During Leave: During an Approved Medical, Parental and Caregiver Leave, the Resident must be provided at least the equivalent of 100 percent of their salary. The Resident must first use any sick, vacation, or other paid time off that they have available to make up their salary, provided that doing so is consistent with institutional policy and applicable laws, and that one week of paid time off is reserved for use outside of the first six weeks of leave.

If the Resident has exhausted the amount of paid time off (i.e. sick or vacation) that must be used (per the above explanation), the Resident will be paid 100% of their salary for the remaining amount of leave under this policy.

Health Insurance: If the Resident and/or the Resident's family participate in HRC's group health plan, HRC will maintain coverage under HRC's group health plan during an Approved Medical, Parental and Caregiver Leave on the same terms as if the employee had continued to work. The employee's share of health plan premiums will be deducted from any wages paid while on an Approved Medical, Parental and Caregiver Leave. To the extent that the wages paid during an Approved Medical, Parental and Caregiver Leave are not sufficient to cover the employee's share of health plan premiums, HRC reserves the right to recover premiums that it paid to maintain health coverage or other benefits for the employee or the employee's family.

Return from Leave: Upon returning from an Approved Medical, Parental and Caregiver Leave, Residents will be restored to their original job. Any Resident who fails to return to work as scheduled after an approved leave, including an Approved Medical, Parental and Caregiver Leave, will be subject to HRC's standard leave of absence and attendance policies. This may result in termination if an employee has no other Company-provided leave available that applies to the employee's continued absence.

Impact: Allowable time away from training and the potential need to extend training time will be determined based on ACGME program requirements and the relevant Specialty Board eligibility requirements. All trainees are responsible for understanding the required training time for their specialty and should consult the ACGME and ABPN websites for specific details.

Trainees must be informed by the program director about the impact of time away from training, including LOA's and vacation time, both for the date of program completion and specialty board eligibility. If implementation of the HRC LOA/Vacation policy creates conflict with a Specialty Board's policy for absences for training, (e.g., the HRC LOA/Vacation policy is more liberal than the Specialty Board's) the program must comply with the Specialty Board's requirements.

It is an expectation that each trainee should meet the requirements to be eligible for ABPN or AOA board certification in their specialty to successfully complete a HRC ACGME program. Programs should assess the number of each trainee's non-work days as part of their Clinical Competency Committee (CCC) processes to determine whether the trainee may be promoted within or complete a program. In general, extension of time in training, if required, that results from leaves of absence should be added to the training level when the leave occurred. Other than adjustments for the required amount of time spent in training, each trainee must achieve all requirements of the training program. These include all mandatory or required rotations, an appropriate amount of night, weekend and call experiences, and availability for backup coverage expected of trainees as a team member, unless otherwise prohibited by ACGME or ABMS policy. The Program Director, advised by the CCC in ACGME programs, is responsible for determining the readiness of any trainee for promotion, program completion and board eligibility. Decisions to delay promotion or extend training to ensure that the trainee has met or will meet all program requirements are permissible, and the program director, advised by the CCC, has the responsibility for determining the need for delayed promotion or extensions of training. Delayed promotions and/or extensions of training time that occur as a result of LOAs will not be considered corrective actions.

Educational Leave/ Conference Time

Attendance at educational, scholarly, and professional activities is scheduled by mutual agreement with the Residency Program. Residents are allowed 4 days of educational leave per academic year.

Clinical Work Hours and Timekeeping

Tardiness and Early Departure

Residents are expected to arrive on time and prepared for shifts and complete assignment and tasks promptly.

Resident Fatigue

The ACGME requires all training programs to educate faculty and residents on fatigue and sleep deprivation. Residents will learn to recognize the signs and symptoms of fatigue to understand the impact of fatigue on patient-care.

Hours

ACGME refers to duty hours as Clinical and Educational Work Hours ("Work Hours") and defines them as "all clinical and academic activities related to the program: patient care (inpatient and outpatient); administrative duties relative to patient care; the provision for transfer of patient care; time spent on in-house call; time spent on clinical work done from home; and other scheduled activities, such as conferences. These hours do not include reading, studying, research done from home, and preparation for future cases"[3].

Work Hour Rules

1. Maximum Work Hours per Week
    - Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, moonlighting and clinical work done at home.
2. Mandatory Time off
    - Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational and administrative activities.
    - Residents should have 8 hours off between scheduled clinical work and education periods. Adequate time for rest and personal activities must be provided between all daily duty periods.
        i. There might be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than 8 hours free of work hours. This must occur within the context of the 80-hour and 1-day-off-in-7 requirements.
    - Residents must have at least 14 hours off free from all educational and clinical work after 24 hours of in-house call.
3. Maximum Period Length
    - Residents may not exceed 24 consecutive hours of clinical work. Residents may remain on duty for up to 4 additional hours to participate in didactic activities, transfer care of patients, and other patient safety activities. No new patients may be accepted after 24 hours of continuous duty.
4. Rules Regarding Call
    - In- house call may not occur more frequently than every third night, averaged over a 4-week period.
    - At-home call (or pager call) is defined as call taken from outside the assigned institution and all clinical work done from home related to at-home call. While this is not subjected to the every-third-night limitation, it is subject to 1-day-off-in-7 and 80-hour rules (averaged over a 4-week period).
    - When residents are called into the hospital from home, those hours are counted toward the 80-hour limit.
    - At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. The Program Director monitors the demands of at-home call and makes scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
5. Night Float
    - Night float must not exceed 50% of a resident's inpatient experience and must occur within the 80-hour and day off-in-7 rules.

Work Hour Compliance

The residency program and institution are required to monitor resident work hours and ensure compliance with ACGME program requirements, this is an accreditation requirement. Residents are responsible for keeping an honest and accurate account of their time spent on clinical duty, call, vacation, and other educational activities, this is also an ACGME requirement[4].

Residents are expected to log work hours in MedHub on a weekly basis. This will be reviewed regularly by the Program Director and coordinator. Delinquencies will be notified by email. Residents who are delinquent in reporting hours may be suspended from duty until hours are current. Assessment of the compliance with these requirements will be done through time studies by the residency office.

Residents must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. The program understands that there may be circumstances when residents must stay on duty to care for their patients. In these cases, please provide the patient's MRN and brief explanation in the duty hour log for that day. If other violations occur, a valid explanation must be entered into the log with the patient's MRN as reference.

You will not be disciplined in the event of a violation (unless there is evidence of abuse or dishonesty). Violations are assessed to determine how they can be avoided in the future and to identify any potential patterns or systemic issues that may contribute to violations. Additionally, the Program Director and Coordinator monitor the demands of the program and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue. The purpose is to ensure your well-being and patient safety.

Residents should be proactive in monitoring their duty hours. Residents should review the schedule and immediately report any potential work hour violations so that a revision can be made in advance.

Resident Impairment

Any resident who believes they may be impaired by physical or mental illness, substance use or any other impairment shall seek the assistance of the Resident Well-Being Committee. A resident who is determined to be impaired during the GME Program will be subject to the HRC policy entitled "Impaired Physician". They may qualify for a medical/personal leave of absence or reasonable accommodation. If you believe another resident or attending physician is impaired, please report this to the Program Director or Program Coordinator immediately.

Moonlighting

The California Postgraduate Training License (PTL) is not considered to be an unrestricted license; therefore, residents are not eligible to apply for moonlighting privileges until PGY-2 once they have a valid Physician's and Surgeon's License. Refer to the program policy on Moonlighting, located in MedHub for further details and process to apply for moonlighting.

[3] ACGME Glossary of Terms dated 4/15/2020

[4] ACGME CPR VI.B.4.f)

Important Numbers

Program Leadership & Attendings

NAME	OFFICE	PHONE	EMAIL
PD: Rachel Mitchell, MD	GME		rmitchell@healthyruralca.org
APD: Romy Kullar, DO	GME		rumkullar@gmail.com
APD: Donovan Wong, MD	GME		dwong@buttecounty.net
PC: Lina Benton	GME	530-999-2629	lbenton@healthyruralca.org
CORE: Duane McWaine, MD	GME		dmcwaine@buttecounty.net
CORE: Meekile Mason, MD	GME		mmason@co.sutter.ca.us
CORE: Harkirat Saggu, MD	GME		Harkiratsaggu78@yahoo.com
CORE: Scott Summers, MD	GME		Scott.summers@va.gov
Program Assistant: Susanna Garcia	GME	925-809-5501	sgarcia@healthyruralca.org
DIO: Ted Zwerdling, MD	GME		Ted.zwerdling@gmail.com

Acknowledgment

I have received and read the Resident's Handbook. I understand its content and will be responsible for abiding with all the guidelines set forth by the Program.

Resident Name:

Resident Signature

Date: