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Acknowledgment of Manual Receipt and Comprehension of Contents
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<thead>
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<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Louis Lambiase, MD</td>
</tr>
<tr>
<td>Residency Program Coordinator and Department Manager</td>
<td>Deborah Fuller</td>
</tr>
<tr>
<td>Administrative Aide</td>
<td>Ashly Herron</td>
</tr>
<tr>
<td>Program Director</td>
<td>Curtis Cary, MD</td>
</tr>
<tr>
<td>Associate Program Director(s)</td>
<td>Radhika Shah, MD</td>
</tr>
<tr>
<td></td>
<td>Jensen Hyde, MD (GMEC Approval Pending)</td>
</tr>
<tr>
<td>Chief Resident</td>
<td>Jarle Stone, MD</td>
</tr>
<tr>
<td>Global and Community Health Track Director</td>
<td>Mike Davis, MD</td>
</tr>
<tr>
<td>Program Director, Cardiology Fellowship</td>
<td>D. Patel, MD</td>
</tr>
<tr>
<td>Program Director, GI Fellowship</td>
<td>Arslan Kahloon, MD</td>
</tr>
<tr>
<td>Medical Student Clerkship Director</td>
<td>Patrick Koo, MD</td>
</tr>
<tr>
<td>Clerkship Coordinator &amp; Internal Medicine Administrative Assistant</td>
<td>Joyce Poke</td>
</tr>
<tr>
<td>Division of General Internal Medicine</td>
<td></td>
</tr>
<tr>
<td>Inpatient Medicine Faculty</td>
<td>Curtis Cary, MD</td>
</tr>
<tr>
<td></td>
<td>Mike Davis, MD</td>
</tr>
<tr>
<td></td>
<td>Jensen Hyde, MD</td>
</tr>
<tr>
<td></td>
<td>Mukta Panda, MD</td>
</tr>
<tr>
<td></td>
<td>Howiada Salim, MD</td>
</tr>
<tr>
<td></td>
<td>Maria Tudor, DO</td>
</tr>
<tr>
<td></td>
<td>Laura Youngblood, MD (Chief)</td>
</tr>
<tr>
<td></td>
<td>Eric McCartt, MD</td>
</tr>
<tr>
<td></td>
<td>Nick Pumilia, MD</td>
</tr>
<tr>
<td>Continuity Clinic Faculty</td>
<td>Gary Malakoff, MD</td>
</tr>
<tr>
<td></td>
<td>Nick Pumilia, MD</td>
</tr>
<tr>
<td></td>
<td>Tracy Dozier, MD</td>
</tr>
<tr>
<td></td>
<td>Ryan Ambrosetti, DO</td>
</tr>
</tbody>
</table>
Division Chiefs
(Appointed by Department Chair)

Cardiology, Harish Manyam, MD
Gastroenterology, Arslan Kahloon, MD
Rheumatology, Michael Brit, MD
Infectious Diseases, James Sizemore, MD
Pulmonary/Critical Care, Jigme Sethi, MD
Endocrinology, Vacant
Nephrology, Christopher Poole, MD
Psychiatry, John Cohen, MD
Hematology/Oncology, Matt Graham, MD
General Internal Medicine, Laura Youngblood, MD

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Location, Whitehall Building
Suite 200
Phone, 423 – 778 – 2998
Email, UTintmed@erlanger.org
Hours, 8:00 AM – 5:00 PM
Monday – Friday
COLLEGE OF MEDICINE MISSION STATEMENT

Dean's Office Mission & Vision

The University of Tennessee College of Medicine Chattanooga (UTCOMC) will be a top-tier medical education/health sciences institution.

MISSION

The mission of the UT College of Medicine Chattanooga is to facilitate and support the education, research, and service goals of the College of Medicine at the University of Tennessee Health Science Center.

Goals

We will educate the future leaders in the field of medicine, "Blending the Art and Science of Medicine", and thus, reduce the burden of human illness and suffering.

Vision Focus Areas

Quality Education - UTCOMC will provide the highest quality of state-of-the-art education for Medical Students, Residents, Fellows, and practicing physicians in an integrated, multidisciplinary environment. Faculty will be recruited, supported, and retained to teach, engage in scholarly activity/clinical research, and provide the highest level of healthcare for area patients.

- Cutting-Edge, Nationally-Recognized Research - Recognizing that medical education must be built on a strong scientific foundation, faculty and students will engage in scientific research projects for the purpose of improving health and reducing the burden of illness globally.
- Health Enhancements for Greater Chattanooga Area (and Beyond) - The region will have improved health outcomes due to the work of the UTCOMC. Many of the institution's students will choose to stay in the region to practice; thus, our excellence translates into better regional healthcare.

Values

- Excellence - Superior performance will be expected from all Faculty, Staff, and Medical Students, Residents, and Fellows.
- Fiscal Responsibility - Fiscal soundness will be the basis for all decisions regarding resources and how those resources are best utilized.
- Compassion and Social Responsibility - Faculty, Staff, Medical Students, Residents, and Fellows will embrace the reason we are here: to contribute to health care one individual at a time. We will never lose sight of the fact that we serve individuals and their families, and they depend on us for their wellbeing.
- Diversity - UTCOMC will recruit, educate, and graduate an increased number of underrepresented minorities, and we will work to reduce health disparities that exist for persons of color.
- Health Access - UTCOMC will work with physically and mentally challenged individuals and organizations advocating for these individuals to ensure access to top-level health care is available for those who may not be able to navigate through and access health services for themselves.
- Medical Community Integration and Enhancement - Recognizing that medical education is best when information is shared among the medical disciplines, UTCOMC will offer educational opportunities where all students, whatever their areas of specialty, will work together and learn that a collaborative medical community is a necessity.

Collaboration

The UT College of Medicine Chattanooga will work to support the Strategic Plan of the University of Tennessee Health Science Center.
ERLANGER HEALTH SYSTEM MISSION STATEMENT

Mission
We compassionately care for people.

Vision
Erlanger is a nationally-acclaimed health system anchored by a leading academic medical center. As such we will deliver the highest quality, to diverse populations, at the lowest cost, through personalized patient experiences across all patient access points. Through innovation and growth, we will sustain our success and spark economic development across the Chattanooga region.

Core Values

Excellence
We distinguish ourselves and the services we provide by our commitment to excellence, demonstrating our results in measurable ways.

Respect
We pay attention to others, listening carefully, and responding in ways that demonstrate our understanding and concern.

Leadership
We differentiate ourselves by our actions, earning respect from those we lead through innovation and performance.

Accountability
We are responsible for our words and our actions. We strive to fulfill all of our promises and to meet the expectations of those who trust us for their care.

Nurturing
We encourage growth and development for our staff, students, faculty and everyone we serve.

Generosity
We are giving people. We give our time, talent and resources to benefit others.

Ethics
We earn the trust by holding ourselves to the highest standards of integrity and professional conduct.

Recognition
We value achievement and acknowledge and celebrate the accomplishments of our team and recognize the contributions of those who support our mission.
STRATEGIC PLAN

MISSION
We compassionately care for people.

VISION
Erlanger is a nationally-acclaimed health system anchored by a leading academic medical center. As such we will deliver the highest quality, to diverse populations, at the lowest cost, through personalized patient experiences across all patient access points. Through innovation and growth, we will sustain our success and spark economic development across the Chattanooga region.

OUR VALUES: EXCELLENCE · RESPECT · LEADERSHIP · ACCOUNTABILITY · NURTURING · GENEROSITY · ETHICS · RECOGNITION

- Improve quality, safety & service
- Advance operational excellence
- Improve financial performance
- Enhance associate & physician engagement
- Improve access & drive service line growth
INTRODUCTION

This document contains the University of Tennessee College of Medicine Chattanooga Internal Medicine Residency house staff rules. Please thoroughly read this document to understand your responsibilities to your patients, your attendings and your fellow residents. This document encompasses rules and policies that you should be not only aware of but always adherent to during your time as a resident in addition to all guidelines and pertinent policies of the University of Tennessee College of Medicine Chattanooga and Erlanger Health System. If a question arises, please consult this manual first as the answer is often just a few pages away. While an attempt has been made to cover all situations and to outline all house staff responsibilities, inevitably some details may be missing. Also, this manual is always a “work in progress.” Change is constant in residency programs and often must be made during the year as deemed necessary to improve the program.

The most important guiding principal for the University of Tennessee College of Medicine Chattanooga Internal Medicine Residency program is the education of our residents. We will always strive to provide the most progressive educational experiences. However, we will always have to coordinate educational and service needs within both the college and the Erlanger Health System enterprise, and, most importantly, our educational program must be in compliance with the Accreditation Council on Graduate Medical Education (ACGME) mandates. If there are any problems with compliance, they must be reported to the residency program director immediately.

PROGRAM MISSION STATEMENT

The University Of Tennessee College Of Medicine Chattanooga Internal Medicine Residency Program is committed to training resident physicians in providing compassionate, evidence based care to diverse patient populations using a curriculum that supports individual resident well-being and empowers a community of future physician leaders. The program will provide a diverse and inclusive academic environment that will fully prepare our graduates for individualized careers in primary care, hospital medicine, academic medicine, and subspecialty training. Residents will be immersed in an environment that fosters teamwork and appreciates high standards in patient safety and quality improvement. The goal will be to produce highly capable board certified internists well rooted in the principles of lifelong learning and of academic inquiry/scholarly activity who can adapt to a dynamic, ever changing health care environment. We will uphold and embrace the highest professional standards in individual comportment while providing patient care and serving as physician leaders that impact not only the individual patient but our community as a whole.

PROGRAM AIMS

1.) To provide, learn, and exemplify the highest standards in patient care by compassionately treating patients with complex medical conditions.
2.) To promote the health and well-being of the local community of Chattanooga and the surrounding area.
3.) To support the research mission of our institution, including contribution to clinical knowledge in our scientific community as well as quality improvement initiatives institutionally.
4.) To uphold excellence in lifelong learning and medical knowledge, including but not limited to Internal Medicine Certification.
5.) To treat all patients, hospital staff, and colleagues with professionalism, kindness, and respect.
6.) To foster an environment of inquiry within oneself and with junior colleagues.
7.) To recognize stewardship of medical resources.
8.) To uphold the standards of University of Tennessee College of Medicine Chattanooga Internal Medicine Residency Program throughout our professional careers through leadership, lifelong learning, and commitment to excellence in patient care.

COMMITMENT TO DIVERSITY AND RESIDENT RETENTION

The program will continue to ensure diversity beginning with a non-biased selection process. The program is open to applicants from accredited US (allopathic and osteopathic) and Canadian medical schools and International Medical Schools that meet standards of licensure for the state of Tennessee (when not able to be determined the program director uses standards employed by the California Board of Medical Licensure as they generate an accessible and complete listing). There is no preference given in respect to age, class, ethnicity, gender, physical and mental abilities, race, sexual orientation, spiritual practice and other human differences - all are given equal footing in the selection process. We only ask that applicants pass USMLE steps 1 and 2 (CK and CS), have done well in medical school with recent experience, and demonstrate sufficient performance judged by both residents and faculty during an in-person onsite interview. The rank list is made by the program director aligning with the aforementioned ideals and strives to align with individuals who want to join our program and will successfully complete our curriculum. Once a resident is enrolled in our program we invest in every individual the full array of mentorship and advising resources we can to make sure the curriculum is individualized when possible and provides longitudinal support for residents among peers, staff and faculty members. Individualized learning plans and strategies for success are highlighted in mentor meetings and reinforced during semi-annual reviews. Progression along the milestones is also visible to all residents via evaluation tools and informatics produced by New Innovations. The program has invested in all individuals matched into our program and above all else we will strive to make sure every intern progresses sufficiently to the point they can graduate, be licensed, and pass the ABIM certification examination.

The program and its sponsoring department align with our accrediting college of medicine and health system in terms on inclusiveness and fostering diversity. Both have officers for diversity and human resource practices that support a diversified faculty and staff population. There is no preference given to candidates with respect to age, class, ethnicity, gender, physical and mental abilities, race, sexual orientation, spiritual practice and other human differences. The department has a history of a well-diversified faculty and staff base that will continue for the foreseeable future.
SUMMARY OF THE PROGRAM’S GRADUATION REQUIREMENTS

AMERICAN BOARD OF INTERNAL MEDICINE (ABIM) CURRICULUM REQUIREMENTS

The information provided on ABIM's website and in ABIM's print publication, Policies and Procedures for Certification, March 2020 (pdf), governs ABIM's decision about eligibility for certification. The March 2020 edition supersedes all previous publications. ABIM reserves the right to make changes in fees, examinations, policies and procedures at any time without advance notice. Admission to ABIM's certification process is determined by policies in force at the time of application. ABIM is a member of the American Board of Medical Specialties (ABMS).
REQUIREMENTS FOR CERTIFICATION IN INTERNAL MEDICINE

To become certified in internal medicine, a physician must complete the requisite predoctoral medical education, meet the graduate medical education training requirements, demonstrate clinical competence in the care of patients, meet the licensure and procedural requirements and pass the Certification Examination in Internal Medicine.

Predoctoral Medical Education

Candidates who graduated from medical schools in the United States or Canada must have attended a school that was accredited at the date of graduation by the Liaison Committee on Medical Education (LCME), the Committee for Accreditation of Canadian Medical Schools, or the American Osteopathic Association.

Graduates of international medical schools must have one of the following: (1) a standard certificate from the Educational Commission for Foreign Medical Graduates without expired examination dates; (2) comparable credentials from the Medical Council of Canada; or (3) documentation of training for those candidates who entered graduate medical education training in the United States via the Fifth Pathway, as proposed by the American Medical Association.

Graduate Medical Education

To be admitted to the Certification Examination in Internal Medicine, physicians must have satisfactorily completed, by August 31 of the year of examination, 36 calendar months, including vacation time, of U.S. or Canadian graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada, or the Collège des médecins du Québec. Residency or research experience occurring before completion of the requirements for the MD or DO degree cannot be credited toward the requirements for certification.

The 36 months of residency training must include 12 months of accredited internal medicine training at each of three levels: R-1, R-2, and R-3. No credit is granted for training repeated at the same level or for administrative work as a chief medical resident. In addition, training as a subspecialty fellow cannot be credited toward fulfilling the internal medicine training requirements.

TRAINING AND PROCEDURAL REQUIREMENTS

<table>
<thead>
<tr>
<th>MINIMUM MONTHS OF TRAINING</th>
<th>CLINICAL MONTHS REQUIRED</th>
<th>PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>36*</td>
<td>30</td>
<td>• Procedures are essential to internal medicine training; to be eligible for certification, all residents must perform procedures during training.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not all residents need to perform all procedures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Program directors must attest to general competence in procedures at end of training.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• At the completion of training, residents must have demonstrated effective consent discussions, standard or universal precautions, establishment of a sterile field, and application of local anesthetic as applicable to most procedures a resident may perform.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Residents must have the opportunity to develop competence in procedures which will further their development as fellows in their chosen subspecialty or as independent practitioners in their intended fields if entering practice after residency.</td>
</tr>
</tbody>
</table>

* For defects of less than 35 days in required training time, AABIM will defer to the judgment of the program director and promotions or competency committee in determining the need for additional training. With program director attestation to AABIM that the trainee has achieved required competence, additional training time will not be required. Trains cannot make a request to AABIM on their own behalf.
Content of Training

The 36 calendar months of full-time internal medicine residency education:

(1) Must include at least 30 months of training in general internal medicine, subspecialty internal medicine and emergency medicine. Up to 4 of the 30 months may include training in areas related to primary care, such as neurology, dermatology, office gynecology or office orthopedics.

(2) May include up to three months of other electives approved by the internal medicine program director.

(3) Includes up to three months of leave for vacation time. (See "Leave of Absence and Vacation Policy")

(4) For deficits of less than one month in required training time, ABIM will defer to the judgment of the program director and promotions or competency committee in determining the need for additional training. With program director attestation to ABIM that the trainee has achieved required competence, additional training time will not be required. Trainees cannot make a request to ABIM on their own behalf.

In addition, the following requirements for direct patient responsibility must be met:

(1) At least 24 months of the 36 months of residency education must occur in settings where the resident personally provides or supervises less experienced residents who provide direct care to patients in inpatient or ambulatory settings.

(2) At least six months of the direct patient responsibility on internal medicine rotations must occur during the R-1 year.

Procedures Required for Internal Medicine

The exposure to the performance of, and the opportunity to develop competence in, invasive procedures by residents is essential for internal medicine residents’ preparation for their subsequent subspecialty fellowship or chosen career path.

As of the 2019–2020 academic year, residents must meet the requirements outlined in the table above to be admitted to the Internal Medicine Certification Examination. Internal medicine graduates will likely perform some invasive procedures in the course of their future training or practice; however, the specific procedures will vary based on subsequent subspecialty, hospitalist or general career path taken. The performance of all invasive procedures requires the ability to facilitate an effective discussion with patients regarding risk and benefit of the procedure before obtaining consent, a critical task that all internists must effectively perform. Internists who perform any invasive procedures must be able to initiate a standardized preparation beforehand including hand washing, donning of sterile gloves, preparation of the procedural field, and application of some form of anesthetic. Procedural competence need not be determined solely by a minimum number of successfully completed procedures but may be customized as appropriate through simulation, direct observation, and other criteria determined by the program director and clinical competency committee.

Clinical Competence Requirements

ABIM requires documentation that candidates for certification in internal medicine are competent in: (1) patient care and procedural skills; (2) medical knowledge; (3) practice-based learning and improvement; (4) interpersonal and communication skills; (5) professionalism; and (6) systems-based practice.

Through its tracking process, FastTrack®, ABIM requires verification of candidates’ clinical competence from an ABIM certified program director (other ABMS Board and Canadian certification is acceptable, if applicable). See the table on page 3.

In addition, candidates must receive satisfactory ratings in each of the ACGME/ABMS Competencies and the requisite procedures during the final year of required training. It is the candidate’s responsibility to arrange for any additional training needed to achieve a satisfactory rating in each component of clinical competence.

As outlined in the table above, all residents must receive satisfactory ratings in overall clinical competence in each year of training. In addition, residents must receive satisfactory ratings in each of the ACGME/ABMS Competencies during the final year of required training. It is the resident’s responsibility to arrange for any additional training needed to achieve a satisfactory rating in each component of clinical competence.
**PROGRAM DIRECTOR RATINGS OF CLINICAL COMPETENCE**

<table>
<thead>
<tr>
<th>COMPONENTS AND RATINGS</th>
<th>RESIDENTS/FELLOWS: NOT FINAL YEAR OF TRAINING</th>
<th>RESIDENTS/FELLOWS: FINAL YEAR OF TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Clinical Competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This rating represents the assessment of the resident’s development of overall clinical competence during this year of training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfactory or Superior</td>
<td>Full credit</td>
<td>Full credit</td>
</tr>
<tr>
<td>Conditional on Improvement</td>
<td>Full credit</td>
<td>No credit, must achieve satisfactory rating before receiving credit*</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>No credit, must repeat year</td>
<td>No credit, must repeat year</td>
</tr>
</tbody>
</table>

**Six ACGME/ABMS Competencies**

The resident is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in training. He/she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient and equitable care.

<table>
<thead>
<tr>
<th></th>
<th>RESIDENTS/FELLOWS: NOT FINAL YEAR OF TRAINING</th>
<th>RESIDENTS/FELLOWS: FINAL YEAR OF TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Full credit</td>
<td>Full credit</td>
</tr>
<tr>
<td>Conditional on Improvement</td>
<td>Full credit</td>
<td>No credit, must achieve satisfactory rating before receiving credit*</td>
</tr>
<tr>
<td>No</td>
<td>Full credit</td>
<td>No credit, must repeat year</td>
</tr>
</tbody>
</table>

*At the discretion of the program director, training may be extended so that the resident or fellow can attain satisfactory competence in overall clinical competence and/or the six ACGME/ABMS Competencies.

**The six ACGME/ABMS Competencies are:**
1. Patient care and procedural skills
2. Medical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

**PROGRAM LISTING OF REQUIRED PROCEDURES**

The program expects all residents to be aware of the indications for and the delivery of the listed procedures. Proficiency of their completion and documentation of this in New Innovations will be tracked throughout your training.

**Knowledge competence** includes knowing and understanding the following for each procedure:

<table>
<thead>
<tr>
<th>Indications</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition and Management of Complications</td>
<td>Pain Management</td>
</tr>
<tr>
<td>Appropriate Use of Sterile Technique</td>
<td>Specimen Handling</td>
</tr>
<tr>
<td>Interpretation of Results</td>
<td>Aspects of Obtaining and Knowledge of Informed Consent</td>
</tr>
</tbody>
</table>

All procedures must be logged into New Innovations. If a resident desires to obtain performance competence in a procedure that is not required, he/she should notify the program director so the appropriate learning experience can be arranged. Before residents can supervise or teach any procedures, required or optional, to
other residents or interns, the supervising resident must have successfully performed and completed the requisite number of the corresponding procedure as listed in the table below. Only after then will they be deemed competent to perform the procedure independently after obtaining approval from their supervising attending and consent from the patient. Observation and simulation of any procedure is not sufficient for the consideration of competency to perform the procedure. We would encourage residents to continue logging procedures even after the minimum numbers of procedures is met for graduation as this is useful for post-residency credentialing and hospital privileges.

### Competency is required in the following procedures:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Know, Understand and Explain</th>
<th>Perform Safely and Competently</th>
<th>Number Needed to be deemed “competent”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal paracentesis</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Advanced cardiac life support</td>
<td>X</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Arterial line placement</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Arthrocentesis</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Central venous line placement</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Drawing venous blood</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Drawing arterial blood</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Incision and drainage of an abscess</td>
<td>X</td>
<td>X</td>
<td>3</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nasogastric intubation</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pap smear and endocervical culture</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Placing a peripheral venous line</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Pulmonary artery catheter placement</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Thoracentesis</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
</tbody>
</table>
PROGRAM DESCRIPTION OF ROTATIONS

<table>
<thead>
<tr>
<th>Direct Patient Care Months</th>
<th>Additional IM Rotations</th>
<th>Non-Medicine Electives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory General Medicine</td>
<td>Dermatology</td>
<td>Radiology</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Endocrinology</td>
<td>Research</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Geriatrics</td>
<td>Surgical Critical Care</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Neurology</td>
<td></td>
</tr>
<tr>
<td>Global Health</td>
<td>Outpatient Cardiology</td>
<td></td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>Outpatient Gynecology</td>
<td></td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Outpatient Pulmonology</td>
<td></td>
</tr>
<tr>
<td>Inpatient General Medicine</td>
<td>Point of Care Ultrasound</td>
<td></td>
</tr>
<tr>
<td>Inpatient Cardiology</td>
<td>Psychiatry</td>
<td></td>
</tr>
<tr>
<td>Inpatient Night Medicine</td>
<td>Resident as Teacher</td>
<td></td>
</tr>
<tr>
<td>Inpatient Pulmonology</td>
<td>Rheumatology</td>
<td></td>
</tr>
<tr>
<td>Nephrology</td>
<td>Sleep Medicine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sports Medicine</td>
<td></td>
</tr>
</tbody>
</table>

ACGME INTERNAL MEDICINE RESIDENCY REVIEW COMMITTEE (RRC) CURRICULUM REQUIREMENTS

Full versions of the latest accreditation requirements can be found at:

https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements

The program utilizes a 4 + 1 scheduling model. Residents have 4 weeks of inpatient or elective rotations followed by 1 week of ambulatory medicine where their longitudinal continuity clinic experience is also conducted.

A block has a duration of 2 calendar weeks.

*Supervisory role during rotation.

*Electives for 2nd and 3rd year residents must include at least one block of Psychiatry, Geriatrics/Palliative Care, and Point of Care Ultrasound during any timeframe encompassing those 2 years. Residents may ask to have more time on these electives.
PROGRAM STANDARDS

➢ Successful progress through the ACGME/ABIM Milestones as determined by the Clinical Competency Committee.

www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/InternalMedicineMilestones.pdf

➢ Demonstration of competence in all core competencies on monthly and semi-annual evaluations.

   a. Unsatisfactory/Marginal performance on evaluations may require repeating a rotation at the discretion of the program director and/or the clinical competency committee.

➢ Direct observations in both inpatient and outpatient settings.

   a. Interns: 2 outpatient and 2 inpatient evaluations within the first 6 months
   b. Residents: 1 outpatient and 1 inpatient evaluation completed by March 30
   c. Handover: 1 per year completed by March 30

➢ Completion of the resident scholarly activity requirement.

➢ A passing score on USMLE Step 3 is required before promotion to PGY2. Residents must be registered to take the exam by February 28 of PGY-1 year in order to have results back in time for promotion by July 1. Failure to pass USMLE Step 3 before the end of the 1st year may be grounds for non-reappointment or dismissal from the program.

➢ Every resident must evaluate each rotation, attending, assigned peers, and the program. These evaluations must be completed within 14 days of the completion of the activity.

➢ Residents must maintain an active (and in no way let it expire or lapse) ACLS certification during all 3 years of residency. Failure to maintain this certification may cause removal from duty until the ACLS certification is again deemed active which could prolong training or result in the forfeiture of pay for any time away from work.

➢ Attendance at scheduled conferences is expected.

   a. Failure to meet a minimum of 75% attendance will result in referral to the clinical competency committee.

➢ You are required to contact your supervising attending and the chief resident (or their assigned designee) concerning any and all absences from rotations.

➢ All schedule changes and/or requests must go through the chief resident and be approved by the program director.

➢ Completion of all program assignments as assigned and directed by the program director.

➢ Completion of patient medical and program records are a required milestone and competency that will be tracked and is required and expected from all residents. Medical records and compliance logs are an
intricate part of patient care. Our program expects residents to meet deadlines and meet all of our expectations concerning their completion.

a. Daily Inpatient Progress Notes: As dictated by assigned service. Generally should be complete by 2 - 3 PM.

b. Outpatient Progress Notes: Notes should be completed before the end of the clinic session. All notes must be finalized within 24 hours of seeing the patient.

c. Inpatient Discharge Summaries: Ideally these documents should be completed at the time of discharge but must be completed no later than 24 hours from the patient’s departure from the hospital.

d. Duty Hour Logging: **No more than 6 days should expire without logging duty hours.**

e. Email: You will be contacted through email for many things and we expect you to check email daily when you are assigned for duty. We will only use your Erlanger issued email and expect that you use it for all residency/work related items.

- Adherence to all college and health system policies regarding professionalism, dress, patient privacy, and communication standards.
- Active participation and completion of required mentorship program tasks.
MENTORSHIP PROGRAM

The program utilizes a mentorship program with the end goal of assisting in the residents’ longitudinal development and accomplishing their career goals, with reflection on their strengths and weaknesses, while ensuring progression along the program requirements toward graduation and career success. Every resident will be assigned a primary mentor. Mentorship pairing is initially set based on the program leadership’s assessment of fit, academic interest and compatibility amongst faculty volunteers with training and interest in mentorship. Assignments can be changed with communication between the mentee-mentor and program leadership. Secondary mentors can also be identified to aid in resident development.

Formal mentorship meetings should occur regularly but are designed at a minimum to occur biannually. We are expecting the meetings to ideally occur during the months of October and March. Prior to the meeting, the resident will perform a self-assessment evaluation (housed in New Innovations) which will be reviewed by the mentor alongside other evaluations and performance data at the mentorship meeting. We have developed a form/tool to document these meetings which then can be subsequently reviewed by the program leadership and clinical competency committee.

Informal mentorship activities are encouraged but not mandated by the residency program. Opportunities for scholarly collaboration, wellness promotion, planning for study and board exam preparation, career planning, etc. are pursued based on the interest and initiative of the mentee-mentor pair.

Mentor Listing for 2020 – 2021:

<table>
<thead>
<tr>
<th>Mentee</th>
<th>Mentor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdelgadir</td>
<td>Salim (Hospital Medicine)</td>
</tr>
<tr>
<td>Amjed</td>
<td>Nagireddy (Hematology/Oncology)</td>
</tr>
<tr>
<td>Ash</td>
<td>Manyam (Cardiology)</td>
</tr>
<tr>
<td>Bond</td>
<td>Youngblood (Hospital Medicine)</td>
</tr>
<tr>
<td>Brit</td>
<td>Crowe (Rheumatology)</td>
</tr>
<tr>
<td>Campbell</td>
<td>Manyam (Cardiology)</td>
</tr>
<tr>
<td>Cataldo</td>
<td>Stevens (Cardiology)</td>
</tr>
<tr>
<td>Colby</td>
<td>Greenberg (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Dias</td>
<td>Greenberg (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Emery</td>
<td>Stevens (Cardiology)</td>
</tr>
<tr>
<td>Erickson</td>
<td>Manyam (Cardiology)</td>
</tr>
<tr>
<td>Gamage</td>
<td>Youngblood (Hospital Medicine)</td>
</tr>
<tr>
<td>Hinson</td>
<td>Sethi (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Name</td>
<td>Specialization</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Hornsby</td>
<td>Davis (Infectious Diseases/Hospital Medicine)</td>
</tr>
<tr>
<td>Jung</td>
<td>Koo (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Kremser</td>
<td>A. Cohen (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Malpartida</td>
<td>Malakoff (General Internal Medicine)</td>
</tr>
<tr>
<td>Mims</td>
<td>Kahloon (Gastroenterology)</td>
</tr>
<tr>
<td>Mok</td>
<td>Stevens (Cardiology)</td>
</tr>
<tr>
<td>O’Dell</td>
<td>D. Patel (Cardiology)</td>
</tr>
<tr>
<td>Oelsner</td>
<td>Shah (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Okereke</td>
<td>Koo (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Palacios</td>
<td>Salim (Hospital Medicine)</td>
</tr>
<tr>
<td>Shapiro</td>
<td>A. Cohen (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Sneij</td>
<td>D. Patel (Cardiology)</td>
</tr>
<tr>
<td>Sonti</td>
<td>Shah (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Sweets</td>
<td>Davis (Infectious Diseases/Hospital Medicine)</td>
</tr>
<tr>
<td>Warren</td>
<td>Vardhana (Hematology/Oncology)</td>
</tr>
<tr>
<td>Wolf</td>
<td>Mainardi (Pulmonary/Critical Care)</td>
</tr>
<tr>
<td>Yadav</td>
<td>D. Patel (Cardiology)</td>
</tr>
<tr>
<td>Zavala</td>
<td>Shah (Pulmonary/Critical Care)</td>
</tr>
</tbody>
</table>
The University of Tennessee College of Medicine Chattanooga Internal Medicine Program provides an ample platform for residents to comply with the ACGME requirements for scholarly activity (Table 1).

Our program promotes and nurtures resident scholarly activity with the following objectives in mind:

- Train the next generation of clinical investigators and physician-scientists
- Promote intellectual and academic curiosity
- Support academic subspecialty fellowship applications
- Lay the foundation for successful careers in general and academic medicine

Internists should be not only familiar with evidence based medicine and the foundations of research from bench to the bedside but are encouraged to participate in research while in residency as the academic structure of the college provides the needed resources for the learner to successfully engage in these activities. Residents should refer to Table 2 for additional details relative to research.

Completion of this requirement is mandatory without exceptions. Residents are responsible for providing to the program coordinator a copy of all abstracts, manuscripts, workshop handouts, etc. for which the resident desires credit for the scholarly activity requirement in a timely manner (within 30 days of completion or acceptance of the activity). All activities must comply with institutional IRB requirements and all projects must be overseen by a faculty mentor.

The current and applicable requirement for scholarly activity of all residents as of February 5, 2019 states: All residents must complete a rigorous Quality and Safety curriculum with projects in the second and third year and must do one of the following during their residency:

Option 1: Manuscript or Book Chapter Publication
Option 2: Presentation at a National, Regional or State Meeting (Original Research or Clinical Vignette)
Option 3: Local Workshop Presentation approved by PD and Mentor or Grand Rounds Presentation

Successful documentation of completion of one of the above options is mandatory for successful completion of residency and ability to sit for credentialing examinations.

### TABLE 1: ACGME INTERNAL MEDICINE RRC REQUIREMENTS FOR SCHOLARLY ACTIVITY

<table>
<thead>
<tr>
<th>RRC IM Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV.B.1</td>
<td>The curriculum must advance resident’s’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core Requirement)</td>
</tr>
</tbody>
</table>
Residents should participate in scholarly activity.
(Core Requirement)

The sponsoring institution and program should allocate educational resources to facilitate resident involvement in scholarly activities.
(Core Requirement)

**TABLE 2: RESEARCH PRIMER**

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>The research component of resident training is aimed to establish competency in the design, conduct, interpretation, and presentation of research by encouraging the resident to complete at least one major project and to participate in additional projects, time permitting. The expected benefit of secondary projects includes the opportunity to enlarge upon previous research and topics, the opportunity for co-resident mentorship, and opportunities for additional authorships. The research experience is based on a mentorship model where the resident and faculty research mentor will collaborate to develop and execute a research project. Selection of clinical research projects follows a similar protocol; that is, the resident research interest should match with the appropriate faculty mentor.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Available Study Designs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prospective Clinical Studies:</strong></td>
</tr>
<tr>
<td>Studies in which data is collected prospectively whether a clinical trial or a prospective observational study. As such studies take a significant amount of time in data collection; residents are encouraged to identify a research topic and faculty mentor very early, preferably within few months of starting residency.</td>
</tr>
</tbody>
</table>

| Retrospective Clinical Studies: |
| In these studies, data has already been collected, generally during clinical encounters. Depending on the study question, these studies can take a significant amount of time as often data needs to be pulled from medical records. Ideally, these studies should be started within the first year of residency. Residents are strongly encouraged to identify mentors (seek help from PD or APD if you have difficulty in identifying mentors) during the first year of residency. |

| Meta-analysis and Systematic Reviews: |
| These studies summarize results from published literature and build evidence-base that can be ultimately used for developing guidelines. Often, a team of two or more investigators is needed and literature review and analysis may take up to a year. Residents interested in working on a meta-analysis/systematic review should start |
working on it during the latter part of the first year or early part of the second year of residency.

**Secondary Data Analysis:**

Residents who are comfortable with statistical analysis or who want to learn statistical analysis may want to analyze publicly available dataset for their question. Several datasets are available including NHANES, CHANES, and CMS datasets from Hospital Compare website. Residents should start their project during the latter part of the first year or early part of the second year of residency.

All research conducted and case reports prepared by a resident must meet IRB standards. Case reports and vignettes should also follow applicable institutional policies including the completion of form H.


**LONGITUDINAL QUALITY IMPROVEMENT CURRICULUM**

The department and the residency program will align with both the University of Tennessee College of Medicine Chattanooga and Erlanger Health System in their quality missions and in doing so will meet accreditation standards for quality and patient safety as outlined by the RRC for Internal Medicine. The chair and a designated departmental quality officer will work with program leadership in the design, implementation, and execution of a longitudinal quality and patient safety curriculum as described below. Interdisciplinary patient safety conferences utilizing root cause analysis will also be held 5 – 6 times per year. Residents will be provided time during their ambulatory week to fulfill the requirements of the quality curriculum.

**Educational Requirements:**

- **PGY-1**
  - Complete IHI patient safety modules (PS 101-105)
  - Demonstrate ability to enter event into E-safe
  - Attend monthly quality oversight committee (QOC) meetings

- **PGY-2**
  - Complete IHI Improvement modules (QI 101-105)
  - Attend monthly QOC meetings
  - Participate in patient safety or quality committee (optional)

- **PGY-3**
  - Complete modules for Basic Certificate in Quality and Safety (TA 101, PFC 101, L 101)
  - Attend monthly QOC meetings
  - Complete High Value Care project
    - Residents must chose a topic of interest relative to high value care and create a 15 – 30 minute conference presentation on their chosen topic for noon conference.

**Quality Improvement Project(s):**
All residents must complete a quality improvement project at some point during their residency. The program encourages this to be done in the first and/or second year of residency. The project must comply with standards set forth by the program and the GME office. All projects must have an identified faculty mentor from start to finish and should be submitted to the IRB for approval so any collected data can be presented in an oral or print presentation. Residents may choose to work individually on this project or can work in groups. The project should be of enough substance so that it is eligible for presentation at a local, regional, or national meeting.

**RESIDENT CLINICAL EXPERIENCE AND EDUCATIONAL WORK HOURS (DUTY HOURS)**

**ACGME REQUIREMENTS FOR CLINICAL EXPERIENCE AND EDUCATIONAL WORK HOURS**

1. Residents may not work more than 80 hours a week, when averaged over 4 weeks (includes moonlighting hours).
2. Residents must have 1 day off in 7, when averaged over 4 weeks.
3. Resident should have 8 hours off between duty assignments.
4. Residents may not work more than 24 hours/shift, plus may spend up to an additional 4 hours to ensure an appropriate, effective, and safe transition of care and maintain continuity of care.
5. Residents must have at least 14 hours off following 24 hours of in-house call.

The department strictly adheres to and monitors work hour compliance. Please enter hours in the New Innovations (NI) Duty Hours Module daily. The GME Office requires that residents update work hours reporting at least every 7 days. Those who fail to update work hours every 7 days are not in compliance with GME Institutional Policy which is monitored by the GME Office and can be subject to disciplinary action.

**NEW INNOVATIONS**

1. Hours you are in the hospital during most days should be logged as “Regular Duty”.
2. Only 24 hours shifts should be designated as “Call”. All else should be entered into the system as regular duty.
3. Duty Hour Types:
   a. Regular – the majority of shifts will be entered in NI as regular duty.
   b. Call – a 24-hour in-house overnight shift.
   c. Post Call – begins after the 24-hour in-hospital overnight call, and is limited to 4 hours to complete handover and patient care. This must be logged separately.
   d. Night Float
   e. Moonlighting
   f. Vacation/Leave – vacation, personal days, or sick days.
   g. Regular “off” days from a rotation do not need to be logged.
   h. Exceptional Circumstances – Residents can stay over 24 hours to care for an end-of-life patient and their family or participate in a rare or unusual education opportunity. Explanation/justification must be entered by the Resident and must be reviewed and approved by the Program Director or his or her designee.
i. Work from Home – Residents can log the patient care time they spend working at home, such as charting or taking phone calls. This does not include studying, reading, or other scholarly activity such as research and personal work on presentations.

**SUPERVISION**

The Department of Internal Medicine will ensure that all patient care is supervised by qualified faculty. Faculty schedules will be structured to provide residents with continuous supervision and consultation. Attending supervision should be adequate to provide quality patient care, and at times will require the daily examination and evaluation of the patient. At other times, this supervision may be accomplished by discussion during teaching rounds. A resident may request the physical presence of an attending at any time and is never to be refused. Attendings will be available for immediate consultation by pager/phone 24 hours a day.

Refer to the following definitions for physicians providing supervision:

- **Attending of Record**: Faculty member responsible for the service to which a patient is assigned.
- **Supervising Physician**: Attending or upper-level resident who is directly or indirectly supervising the patient care activities of interns.

Refer to the following definitions for supervision which provides graduated authority and responsibility:

- **Direct Supervision**: Supervising physician is physically present with the resident and patient.
- **Indirect Supervision (with direct supervision immediately available)**: Supervising physician is physically within the hospital or other site of patient care, and is *immediately* available to provide direct supervision.
- **Indirect Supervision (with direct supervision available)**: Supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by phone/text, and can be on site expediently to provide direct supervision if needed.
- **Oversight**: Supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Duties that require a verbal discussion may be performed but should be discussed prior with the supervising physician, except in the case of an emergency. The supervising physician will then decide if the resident should perform this duty with indirect or direct supervision. The ultimate decision always rests with the attending of record or on-call attending physician.

Duties that require direct supervision are performed with the supervising physician present with the patient.
## INTERN SUPERVISION REQUIREMENTS

<table>
<thead>
<tr>
<th>Indirect supervision with direct immediately available</th>
<th>Direct Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Evaluate unstable patients</td>
<td>Administration of anti-arrhythmics</td>
</tr>
<tr>
<td>Perform a history and physical</td>
<td>Make a DNR order</td>
</tr>
<tr>
<td>Order routine medications</td>
<td>Resuscitation from shock</td>
</tr>
<tr>
<td>Order diagnostic tests</td>
<td>Transfer a patient to the ICU</td>
</tr>
<tr>
<td></td>
<td>Ventilator management</td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>Intravenous line placement</td>
<td>Incision and drainage of abscess</td>
</tr>
<tr>
<td>Nasogastric tube placement</td>
<td>Arterial blood draw</td>
</tr>
<tr>
<td>Pap smear and endocervical culture</td>
<td>Arterial line placement</td>
</tr>
<tr>
<td>Urinary catheter placement</td>
<td>Arthrocentesis</td>
</tr>
<tr>
<td>Venous blood draw</td>
<td>Bone marrow biopsy</td>
</tr>
<tr>
<td></td>
<td>Central venous line placement</td>
</tr>
<tr>
<td></td>
<td>Endoscopy</td>
</tr>
<tr>
<td></td>
<td>Endotracheal intubation</td>
</tr>
<tr>
<td></td>
<td>Lumbar puncture</td>
</tr>
<tr>
<td></td>
<td>Paracentesis</td>
</tr>
<tr>
<td></td>
<td>Pulmonary artery catheter placement</td>
</tr>
<tr>
<td></td>
<td>Thoracentesis</td>
</tr>
</tbody>
</table>

All interns are required to be certified in Advanced Cardiac Life Support (ACLS), and should perform all procedures required regardless if the supervising physician is present in emergent situations.

When an intern is working, an upper-level resident or attending physician must be physically present in the same building.

Interns are expected to contact the supervising physician (either upper-level resident or attending) in the following circumstances:

1. **Significant change in patient condition:**
   - Transfer of the patient to the intensive care unit
   - Need for intubation or ventilator support
   - Cardiac arrest or significant changes in hemodynamic status
   - Development of significant neurological changes
   - Development of major wound complications
   - Any significant clinical problem that will require an invasive procedure or operation
   - Change in code status (upper level and attending should be notified)

2. **Patient death (expected or unexpected)**
3. **Treatment error or complication**
4. **New patient admission to the hospital or patient transfer from another facility**
   a. **Stable Patients:** Interns should notify their supervisory physician at the earliest time convenient that does not interfere with his/her patient care duties.
b. Unstable Patients: If after preliminary evaluation and assessment an unstable patient is identified, the supervising physician should be notified immediately (guideline of 5 minutes).

5. Patient requesting to leave the hospital against medical advice (AMA)
6. Patient or family request for a discussion with supervising physician

### UPPER-LEVEL RESIDENT SUPERVISION REQUIREMENTS

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Oversight</th>
<th>Indirect supervision with direct available (verbal discussion)</th>
<th>Direct supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evaluate unstable patients</td>
<td>Administration of anti-arrhythmics</td>
<td>Bone marrow biopsy</td>
</tr>
<tr>
<td></td>
<td>Perform a history and physical</td>
<td>Resuscitation from shock</td>
<td>Endoscopy</td>
</tr>
<tr>
<td></td>
<td>Order medications</td>
<td>Ventilator management</td>
<td>Endotracheal intubation</td>
</tr>
<tr>
<td></td>
<td>Order diagnostic tests</td>
<td>Make a DNR order</td>
<td>PA catheter placement</td>
</tr>
<tr>
<td>Procedures</td>
<td>Arterial blood draw</td>
<td>Arterial line placement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incision and drainage of abscess</td>
<td>Arthrocentesis</td>
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<td>Intravenous line placement</td>
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</tr>
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<td></td>
<td>Nasogastric tube placement</td>
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<td></td>
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<tr>
<td></td>
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<td></td>
<td>Urinary catheter placement</td>
<td>Thoracentesis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Venous blood draw</td>
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<td></td>
</tr>
</tbody>
</table>

Upper-level residents should be available at all times to the intern on service and in their absence will assume all primary caregiver responsibilities. Upper-level residents are directly responsible to the attending of record, and should maintain open, continuous lines of communication regarding the status of the patients on the teaching team. On services with upper levels and fellows, residents are responsible to the fellow and attending on the service. As residents progress through upper-level months, increasing responsibility and autonomy are provided by the attending on service, such that by the final inpatient months of training, each resident should essentially be functioning as an attending with regards to medical decision-making.

In the setting of an intern being supervised by an upper level resident, it is expected that the supervising resident examine and evaluate each patient on the service at least daily. The upper-level resident and intern should maintain clear communication about the patient’s care.

Upper-level residents are expected to contact the attending of record or on-call attending in the following circumstances:

1. Significant change in patient condition:
   - Transfer of the patient to the intensive care unit
   - Need for intubation or ventilator support
• Cardiac arrest or significant changes in hemodynamic status
• Any significant clinical problem that will require an invasive procedure or operation

2. Patient death (expected or unexpected)
3. Treatment error or complication
4. New patient admission to the hospital or patient transfer from another facility
   • Stable Patients: Upper-level residents should contact the attending of record or on-call attending after their initial evaluation is complete and at the earliest time convenient that does not interfere with his/her patient care duties.
   • Unstable Patients: If after evaluation and assessment an unstable patient is identified, the attending of record or on-call attending should be notified promptly (guideline of 15 minutes) by one of the team members, unless all team members are needed to stabilize the patient’s condition or coordinate transfer to the ICU. If such a delay is required than a call should be placed as soon as feasible.
5. Patient requesting to leave the hospital against medical advice (AMA).
6. Patient or family request for a discussion with supervising physician.

AMBULATORY SUPERVISION OF ALL RESIDENTS

In clinic, both interns and upper-level residents serve as the primary caregivers to each patient, and are immediately responsible to the attending. Each resident has an increasing degree of responsibility commensurate with his/her level of training. It is important to remember that, while the training program emphasizes resident responsibility for patient care as a principle of learning, the physician who is legally responsible for what happens to a patient is the attending physician of record.

Each patient evaluated by a resident in the University Medical Associates practice has a member of the medical staff as his/her attending physician who is physically present and readily available during the entire clinical encounter. Residents will perform a history and physical examination on the patient and review these findings with the supervising attending physician. The resident will develop an assessment and plan for the patient and this will be discussed with the supervising attending. Interns in their first 6 months of residency will review the plan of care with the patient in the physical presence of the attending physician. After successful completion of the first 6 months of residency, the attending physician will decide which patients he/she must physically see prior to discharge from clinic. Residents will generate a problem-based note summarizing the history, physical examination, assessment and plan for the patient. Each note will be reviewed and signed by the supervising attending. Residents will provide continuity of care for their patients with the guidance of the supervising attending.

FATIGUE MITIGATION & ALERTNESS MANAGEMENT

Every resident receives formal training and education on recognizing the signs of fatigue and sleep deprivation. If at any time a resident feels they that are fatigued or sleep-deprived and therefore cannot perform their patient care responsibilities, they are to immediately notify their supervising physician (always including the attending physician of record). The attending will then relieve the resident of patient care responsibilities and help the resident to arrange transportation home. The resident will also notify the chief resident and program director of their status. The chief resident will utilize the backup coverage system as needed to provide
additional resident coverage for patient care responsibilities. It is the program’s expectation when this system is engaged that the attending of record physically return to the patient care team and direct management of all patient care activities until a full complement of resident members is again available for the appropriate amount of patient care.

Strategic napping is encouraged when necessary and residents have available space in the handover room and assigned call rooms to do so. If residents are unable to perform their clinical duties and require strategic napping, they are to immediately inform the attending physician of record who will replace them on a patient care team until another resident can be pulled from the aforementioned systems as described above.

**TRANSITIONS OF CARE (HANDOFF) POLICY**

All inpatient handoffs will be face to face unless an extraordinary event requires a verbal checkout using a phone. Handoff sessions MUST occur any time there is a change of resident(s) caring for a patient. Examples include outgoing daytime shifts signing out to an overnight shift, overnight shift residents signing out to residents on a daytime shift, or a resident with a day off signing out to the co-resident. The program ensures that housestaff are competent in communicating with team members in the handoff process by direct observation of interns by supervising residents or faculty.

**Procedure for Handoff**

1. The outgoing house staff member reviews the patient information in the EMR. He/she is responsible for reviewing and updating pertinent information relation to diagnoses, procedures, and items that need to be done with any clarifying comments.

2. A designated time and place is set for the handoff. For some services, a preset time and place for the house staff handoff will be established by the program. Others will need to establish a time and place depending upon daily schedules. Regardless, accurate communication requires the following elements be established:
   a. A time window during which non-urgent calls can be delayed and coverage for urgent issues established to provide an uninterrupted opportunity to transition patient care.
   b. A location in a confidential, quiet area with ready computer access.

3. The incoming and outgoing house staff should meet face-to-face with the handoff tool immediately available on the computer. During the dynamic handoff, any misinformation noted on the handoff tool should be immediately corrected.

4. The outgoing house staff should verbally hand over each individual patient, providing the following elements for each individual patient:
   a. Clear identification of the patient by full name and birth date
   b. Statement of the patient’s code status
   c. Summary statement(s) of the pertinent elements of the hospital stay
d. List of essential active issues which the incoming physician may need to be address

e. List of contingency plans, including anticipated issues and suggested remedies for the individual patient

f. List of follow-up activities, including any tests, procedures, or therapeutics which the incoming physician may need to evaluate

5. The incoming house staff should verbally clarify or correct information presented by the outgoing provider. This includes verbally repeating any important information (particularly contingency plans and follow-up activities) to ensure understanding.

6. The program utilizes and promotes competency in the I-PASS handoff system.

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EVALUATION

ROTATION GOALS, OBJECTIVES, AND ASSESSMENTS

The goals and objectives for each rotation are available in New Innovations and should be reviewed prior to the beginning of a rotation. The attending is to verbally provide feedback to team members at a minimum of halfway through the rotation and at the end of the rotation; this is in addition to completing the final written evaluation (within the electronic evaluation system).

Throughout residency training, all residents will receive feedback from multiple evaluators, including but not limited to, attending physicians, peers (fellow and resident), students, ancillary staff, and patients. These evaluations will be available though some may be batched to protect anonymity. Likewise, residents are responsible for providing feedback to students, peers and supervisors. All evaluations of peers, supervising attendings, and rotations are confidential after submission. All identifying information is removed and evaluations are compiled and released in batches to ensure anonymity. The Department of Internal Medicine expects all evaluators to complete evaluations within two weeks of rotation completion. Feedback should be provided in a constructive professional manner.

PROGRAM DIRECTOR SEMIANNUAL EVALUATION

Every resident will meet with the Internal Medicine Program Director or Associate Program Director twice yearly. These meetings are intended to summarize all relevant performance data, create an individualized learning plan for each resident and provide mentorship in career development. In preparation, residents should review their evaluations from all sources and complete any assigned preparation activities.

CLINICAL COMPETENCY AND RESIDENCY QUALITY IMPROVEMENT COMMITTEE (CCC)

The Internal Medicine Program Director is primarily responsible for monitoring resident progress and promotion decisions. The Clinical Competence Committee (CCC) for the Internal Medicine Residency Program is advisory to the Program Director and assists the program director in these functions. At all times, the procedures and policies of the CCC will comply with those of the Graduate Medical Education Committee.

Faculty members are appointed by the Program Director and must be deemed “core faculty”. The committee is composed of the Associate Program Directors, a representative body of core faculty, and the chief resident. Where circumstances warrant, the membership of the committee may be altered to avoid a potential conflict of interest, or to protect the privacy of the resident. The Internal Medicine Residency Program Director will attend the meetings, report on findings, but will be an ad hoc member without an ability to vote on any procedural decisions. A core faculty member will chair the CCC.

The CCC meets at a minimum of twice per year to conduct semi-annual summary performance reviews. The CCC will also convene anytime a resident is referred for noncompliance with residency requirements. A resident may be brought before the CCC for failure to complete any of the residency requirements, including but not limited to failure of any clinical rotation, insufficient progress on evaluations (in any domain), or unprofessional behavior in any venue.
Semiannual reviews will consist of an assessment of progression toward competence determined through a multi-source assessment of each resident. This assessment will be based on the Internal Medicine Milestones as determined by the joint ABIM/ACGME committee in addition to a more general assessment of progression in the ACGME general competencies of medical knowledge, patient care, practice-based learning and improvement, communication and interpersonal skills, professionalism and systems-based practice. Residents will be evaluated on individual rotation requirements, program policies, and institutional policies. The individual components of the CCC assessment include but are not limited to the following:

Medical Knowledge
- Global Faculty Evaluations
- Progression with independent learning and scholarly activities
- Conference attendance
- Progression with Directed Reading

Patient Care
- Global Faculty Evaluations
- Direct Observations
- Procedure Logs

Practice-Based Learning & Improvement
- Global Faculty Evaluations
- Progression with independent learning and scholarly activities
- Involvement and leadership with quality improvement projects

Communication & Interpersonal Skills
- Global Faculty Evaluations
- Multisource Evaluations (Peer, Staff, Patient)
- Direct Observations

Professionalism
- Global Faculty Evaluations
- Multisource Evaluations (Peer, Staff, Patient)
- Direct Observations
- Compliance with duty hours logging
- Compliance with medical records policies
- Conference attendance

Systems-Based Practice
- Global Faculty Evaluations
- Multisource Evaluations (Peer, Staff, Patient)
- Involvement and leadership in quality improvement projects

Each semiannual review will produce a written summary of the resident’s progress in meeting ABIM/ACGME Milestones and program requirements. The summaries will be provided to the Internal Medicine Residency
Program Director to assist in the completion of ABIM/ACGME Milestone progress. If upon review of a resident file the CCC feels ‘action’ is necessary, the resident will be asked to address the committee to discuss the issue in detail. After discussion and deliberation, the CCC can address the issue with a notice of concern, probation, suspension or immediate dismissal. Actions that may adversely impact on health or safety of patients or others are addressed by Probation, Suspension and/or Immediate Dismissal.

The house officer will be notified of any formal decision (Probation, Suspension, Immediate Dismissal) as soon as circumstances reasonably allow, and in most cases four months prior to the end of the contract year. Exceptions to this timeframe would include performance issues that primarily arise within the final four months of the contract year. If a house officer is on probation, and the end of the house officer’s probation period is within four months of the end of the contract year, the fact that the house officer is on probation will serve as notice that the house officer may not be promoted if the probation is not remediated successfully.

The training program must provide evaluation and assessment information to residents in a continuous manner throughout the year. In addition, the training program must provide written summary performance reviews to residents at least semi-annually, in person. A review of the resident’s experience and competence in performing clinical procedures must be included in these summaries. A review of the resident’s progress in meeting ABIM and program requirements must also be performed at this time. Summary performance reviews may be written by program directors, designated faculty members, or members of the CCC. It is also recommended that the resident acknowledge receipt of each summary performance review in writing as detailed in Appendix I.

Committee Composition for 2020 – 2021:

• Co-Chairs:
  – Radhika Shah, MD
  – Jensen Hyde, MD

• Members:
  – Mike Davis (Hospital Medicine/ID)
  – Jay Sizemore (ID)
  – Christopher Poole (Nephrology)
  – Maria Tudor (Hospital Medicine)
  – Gary Malakoff (UMA/Student Clerkship)
  – Jarle Stone (Chief Resident)
  – Jonathan Cohen (Psychiatry)
  – Patrick Stevens (Cardiology)
  – Patrick Koo (Pulm/CC)
  – Nick Pumilia (General Medicine)
  – Dharmendra Patel (Cardiology)

• Ex-Officio:
  – Deborah Fuller (Coordinator)
  – Curtis Cary (PD)
  – Louis Lambiase (Chair)
CRITERIA FOR PROMOTION

Promotion to each subsequent year of training requires demonstrating competence that meets expectations on the specific learning objectives of the evaluations across all clinical rotations during that year of training. Residents failing to meet this standard will be reviewed by the CCC which may elect to withhold promotions and remediate, or promote with an accompanying remediation plan.

IN-TRAINING EXAMINATION

The Department of Internal Medicine provides the opportunity for every resident to take the ACP in-training examination (ITE) annually. Arrangements will be made for residents on services with significant patient workload to take the ITE while their service is covered by other resident(s) or attending(s). Satisfactory performance on the yearly ITE is expected of all residents, defined by achieving a score of at least the 30th percentile for residents at a comparable level of training. Residents not achieving satisfactory performance will meet with the Program Director or Associate Program Director to discuss performance improvement strategies. Residents scoring below the 30th percentile will be excluded from all moonlighting activities.

INDEPENDENT LEARNING ACTIVITIES

One of the core goals of the residency training program is to equip residents with the medical knowledge needed to successfully pass the Internal Medicine certification examination. We have provided residents with an educational curriculum and foundation that will ensure passage of the board exam. At its heart the curriculum includes elements of independent learning activities in addition to attendance of didactic conferences. The residency understands that certain residents may have learning styles that favor certain types of independent learning activities. However, all of the learning activities provide modalities that are effective in preparing for board examinations.

As of February 5, 2019 the program has instituted the completion of a required independent learning activity matrix. This was vetted and approved by the PEC and has objective basis in national trends employed by other residency programs and with local evidence that participation in a directed reading program leads to ITE percentile gains and program increases in first time initial board certification passing rates.

The “matrix” consists of the following:

- **ITE > 30th percentile:**
  - The resident will need to show proof of successful completion of at least 15 MKSAP questions per month for a total of **45 in a quarter**.
  - The resident will need to document in New Innovations the directed reading program which will consist of picking three missed ITE objectives and using the MKSAP text or other applicable resources writing three short one to two sentence high yield facts on the missed topic. This will need to be done for THREE objectives a month for a total of **NINE in a quarter**.

- **ITE < 30th percentile:**
The resident will need to show proof of successful completion of at least 30 MKSAP questions per month for a total of **90 in a quarter**.

- The resident will need to document in New Innovations the directed reading program which will consist of picking three missed ITE objectives and using the MKSAP text or other applicable resources writing three short one to two sentence high yield facts on the missed topic. This will need to be done for SIX objectives a month for a total of **EIGHTEEN in a quarter**.

Resident mentors will be provided with leeway in monitoring of these requirements and can substitute other questions that are close approximations to MKSAP questions. For example, an intern preparing for Step 3 can use u-world questions instead of MKSAP to complete the matrix.

The program will use New Innovations for the directed reading documentation using the “journals” functionality located under the portfolio section (screenshot below).

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**REAPPOINTMENT, PROMOTION, NON-RENEWAL, AND APPEALS POLICIES**

The Department of Medicine follows the University Of Tennessee College Of Medicine Chattanooga Graduate Medical Education Programs Institutional Policy on Resident Re-Appointment, Promotion, and Non-Renewal and Appeals which can be found on the college website.
**INTERNAL MEDICINE DEPARTMENT LEAVE POLICY**

✓ **General Guidelines**

a. Per UT Policy, a UT Resident Time off Sheet must be submitted and signed each month to report all leave, regardless of whether the resident has taken time off for that period.

b. Resident must notify the attending and department of any leave including sick days, personal days, etc. prior to an absence from a rotation.

c. The ABIM requires all internal medicine trainees to complete 33 months of training to be eligible for the medicine board exam; thus, cumulative leave of more than 3 months (thirteen weeks) for any reason will extend the period of training beyond the traditional 36 months.

d. Internal Medicine residents are allowed:
   i. Three weeks (15 working days) of vacation leave per academic year.
   ii. Five personal days total over the 3 year training period.
   iii. One week of Continuing Medical Education each academic year.

e. Reminder for PGY3s: Your appointment ends end June 30th, if you plan to leave prior to June 30th please make sure you have sufficient vacation time.

✓ **Unexpected Absences**

If an emergency situation arises causing you to miss a workday, you should notify your attending immediately. You must also notify the chief resident, program director, and program coordinator. If you are absent from your residency duties for three or more consecutive days, you must provide a statement from your physician that you are medically able to return to duty.

✓ **Vacation Leave**

a. All vacation requests for the entire academic year should be received by the program coordinator no later than July 15. The program understands that things will come up during the year and we will work with residents on an individual basis as well.

b. Residents MAY NOT schedule vacations during Inpatient Medicine, Night Float, Critical Care, Cardiology, or Emergency Medicine.

c. Unused vacation leave cannot be utilized in a subsequent academic year.

d. No more than 1 resident on the same rotation can be scheduled off unless special approval is granted.

e. Vacation leave is granted on a first-come, first-approved policy.

f. Vacation leave is assigned in one week intervals at a minimum (5 business days/7 calendar days).
g. For overseas travel, residents must understand the risk of travel delays and the potential for lengthening the residency duration required to meet ABIM training requirements. If a resident is delayed by more than 60 days from returning to his/her residency assignments because of travel outside of the US, his/her status as a resident in the Internal Medicine Residency may be terminated.

✓ **Extended Vacation Leave**

a. Maximum of 3 weeks consecutively but resident must have sufficient unused vacation time for that academic year.

b. Please request extended leave as soon as possible. Ideally submit, prior to July 1 of the academic year for which the leave is being requested.

✓ **Leave for Presentations at State and National Meetings**

Approval is contingent on the ability to provide adequate patient care coverage as well as academic considerations. An arrangement for the appropriate continuation of patient care duties in his/her absence is the responsibility of the presenting resident and must be approved by the chief resident. If approved, the Department of Medicine will provide residents with reimbursement according to departmental guidelines for presentations at state or national meetings if funding is available through the institution. If the institution is devoid of funding we cannot provide any coverage of costs incurred by the resident to present. No more than one regional or national meeting will be funded (if funds available) during each academic year for a resident to present accepted submissions; however, residents may apply their own unused CME (Continuing Medical Education) funds to attend additional meetings. Requests for funding the presentation of a completed resident Research project which has been accepted for presentation at a regional or national meeting after a resident has already received departmental funding for a regional and a national meeting during that academic year will be evaluated individually. Residents on a Performance Improvement Plan (PIP) or on Probation will not be granted leave from rotations for presentations.

✓ **Leave for Interview Dates**

The Residency Program understands that invitations for fellowship interviews often occur with little advanced notice and offer only a single or limited number of days to interview. Employment interviewing typically offers more flexible scheduling. As soon as an invitation for an interview is received, the resident must contact the chief resident and supervising attending. Residents should have sufficient vacation and/or personal days available for the expected dates of leave if they are not using their allotted days off for that rotation OR arrange coverage with other residents so that no patient care duties of any kind by either party are compromised. A signed leave form must be returned to the Program Coordinator prior to the absence. The resident is responsible for arranging coverage for patient care during his/her absence.

✓ **Sick Leave**

a. Residents are allowed up to 3 weeks (with one weekend for each sick week taken) paid sick leave days per year, if needed

b. Sick days are not carried over from year to year.
c. The resident must provide a physician’s statement to return to residency duties for periods of sick leave of 3 consecutive work days or longer.

d. A resident will not be paid for unused sick leave at the end of the year.

e. The determination as to how the resident will be required to make up time missed due to Sick Leave will be made by the chief resident and/or Program Director, in accordance with residency requirements and board certification requirements.

✓ **Personal Days**

Residents are granted five personal days will be over the 3 years of training. Personal Days cannot be taken on a clinic day. At least a one week notice is expected. A form requesting a personal day must be signed by the attending physician and by the Program Coordinator and then submitted to the Department of Medicine.

✓ **Educational (CME) Leave**

Each resident is provided funds from the university for reimbursement of expenses related to an external conference during each of the three years. The goal of the conference is to update the resident in General Internal Medicine. The following must be met:

a. The conference must be approved by the Program Director.

b. The program agenda must be submitted with the request.

c. At least six hours per day must be devoted to the conference.

d. The content must be devoted primarily to internal medicine or IM procedures.

e. The conference must be in the United States or be the national meeting of a US medical society.

Travel to a conference outside the U.S. must have approval from the Chancellor at the UTHSC campus in Memphis.

Educational leave should be requested 3 months in advance of the trip. The same signatures are required as for vacation leave and must be obtained by the first day of the month prior to the month of the conference. The conference must be a full-day program and not one divided into two to four lectures in the course of a day with the remainder devoted to recreational activities. One-day additional travel time, either to or from the meeting, will be allowed. A total of five weekdays off will be granted for conferences, including travel time. Travel plans, which include completion of a University of Tennessee Authorization for Official Travel Form (T-18), should be coordinated with the Program Coordinator at least one month in advance to secure optimal travel rates. All travel is subject to the University of Tennessee and Erlanger hospital policy and procedures and original receipts are required within 30 days of the travel or expense.

✓ **Leave of Absence, Family Medical Leave, Bereavement Leave**

Please refer to the Institutional GME Leave Policy.

✓ **Holidays**
Due to the 24 hour nature of patient care, residents are not entitled to holiday leave unless the hospital or program service/clinic closes for that holiday. Time off for a holiday is based on a Resident’s or Fellow’s rotation assignment. The department may approve time off on a holiday for a resident who is rotating on a clinic or service that closes due to the holiday.

✔ **Away Rotations**

There is a severely limited availability of away rotations (external to the UT College of Medicine Chattanooga and Erlanger). Away rotations will only be approved for rotation/educational opportunities that are not available at Erlanger and are not available for any first-year resident. Away rotations must be discussed with the program director at least 6 months prior to a desired away rotation. Once approved by the Department, away rotations must also be approved by the Associate Dean/DIO, the Dean, and the Erlanger CEO before arrangements can be finalized with the external institution.

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**REIMBURSEMENT FOR PROFESSIONAL EDUCATIONAL DEVELOPMENT AND TRAVEL**

The Internal Medicine Residency Program has allocated the following annual funding per resident for professional development:

- **PGY-1**: $500
- **PGY-2**: $750
- **PGY-3**: $1,000

All reimbursement for educational materials and travel must be within University of Tennessee fiscal policy guidelines and our UT GME policies.

Regarding reimbursement of books or other non-travel related educational expenses; the resident must have already paid for the items prior to requesting reimbursement. Original receipts must be submitted to the Department of Medicine staff within 30 days of the expense. Residents should allow three weeks for processing from the time the request is received in the Graduate Medical Education (GME) Office. Any unused educational reimbursement at the end of June cannot be carried over to the next year. Payment and reimbursement for educational conferences and materials is provided by the UT Business Office and not by the Department of Internal Medicine.

Approved reimbursable expenses if funds are available:

1. Travel expenses to approved CME conferences planned by ACCME accredited providers. Conferences should be in a specialty related to the Resident’s training and career plans and must be in the continental US or the national meeting of a specialty society or organization. Prior travel authorization and review of the conference brochure or website details must be documented by the department. It is recommended that travel be arranged through the University of Tennessee recognized travel agency, World Travel, to ensure that all University policies are followed.
2. Electronic or web-based educational materials.
3. Video course registration.
5) Board Reviews (hard copy or digital).
6) USMLE Step 3 Prep Course or materials.
7) Membership fee for specialty organizations.
8) USMLE Step 3 registration fee.
9) Smart phone ($250 allowance).
10) Ipad or similar tablet ($250 allowance).
11) Laptop computer ($250 allowance).
12) Small medical equipment such as a stethoscope, surgical loupes, or neural reflex hammer.
13) Question bank or academic resource subscriptions for one year.
14) Encrypted portable USB drive.

Non-approved expenses (may include but are not limited to the following):
1) Certification board exam fees.
2) Medical license fees.
3) Printers.
4) Digital cameras.
5) Smart watches.

Purchase and reimbursement for these educational and professional development expenses must be approved by the Chair and/or Program Director, accompanied by original receipts, and an appropriate expense form must be provided by the Resident and Residency Program Coordinator. Once receipts and expenses have been approved and submitted within the university financial system (IRIS), reimbursement will be processed and payment will be issued via direct deposit into your primary bank account on file.

Receipts and expenses should be submitted within 30 days of purchase of items or travel during the year.

The deadline for submitting all Resident reimbursement receipts, explanations, and travel expense reports to the Business Office each academic year is April 1, with the exception of travel that has been pre-approved but has not yet occurred by April 1.

For Travel Reimbursement from UT

- A UT travel request (T18) must be submitted 1 month prior to travel.
- To be reimbursed for flights, must have original receipt with breakdown of taxes/fees and the receipt must denote coach fare.
- To be reimbursed for hotel, must have original receipt from hotel with breakdown on nightly rate, taxes/fees.
- Rental cars are NOT reimbursable
- Receipts from travel sites such as Expedia, Travelocity, Orbitz, etc., generally will not be honored.
- No package deals which include airfare, hotel, and car rental are permitted through these type travel sites – under any circumstances.
- Again, the University recommends that you arrange travel through the UT recognized travel agency, World Travel, to ensure that all University policies are followed and receipts will meet requirements.
All three inpatient medicine teams are available for daytime admissions from 6 AM to 5 PM.

A member of all three inpatient teams must be present until 5 PM for handover to the night team.

The night team works Monday – Saturday from 5 PM – 6:30 AM. Residents are assigned to night medicine coverage for Sunday nights by the chief resident and will be excused from all patient care duties following their night medicine shift.

All team members must have one day off in a seven day period.

A backup resident is assigned each day in the event the regularly scheduled resident becomes ill and cannot proceed with regular duty.

The backup resident is required to have his/her pager on at all times.

Handover occurs at 6 AM and 5 PM in the Handover Room located on WW7. Handover procedure using I-PASS is expected and required.

The total team census for any team composition cannot exceed ACGME requirements as detailed in the “PATIENT ASSIGNMENTS” section of this manual.

A designated senior resident is responsible for attending all in-hospital “codes” (Code Blue) and will be the code leader. Residents respond to 1st floor codes in the Medical Mall, but do not respond to private doctor offices located on the 2nd floor or above. Internal Medicine residents are expected to respond to Code Blue in the operating rooms. Jumpsuits are available for the responding team to maintain sterile conditions.

Orders must be written by the house staff caring for the patient on teaching services.

Verbal Orders should be avoided and if necessitated they should be signed within 12 hours of placement.

We accept all patient deemed suitable by the emergency medicine attending as needing an admission. If you feel a patient does not warrant admission, let the EM attending know you need to contact your attending. Residents may not refuse an admission, but there may be an attending to attending level discussion.

A full and complete daily progress note is expected on all patients.

Residents should call their attending for backup at any time for any reason.

Changeover for all rotations for both interns and residents will be Mondays.

The senior resident or designee from all three teams must attend discharge planning rounds on 3000 at 11 AM daily.

Night Medicine Additional Information:

- Admit new patients to the program-guidelines team caps: 14 for a 1 intern team, 18-20 for a 2 intern team.
- Once those caps are reached, you may communicate to the ED that the teams are capped. If contacted by hospitalist service or ED for assistance amidst a surge of patients, contact the attending on call for permission to admit up to 3 additional patients to be distributed the following morning. Daytime attending physicians will insure that program caps are not violated.
- Admit no more than 10 patients in a night medicine shift (ACGME Cap for senior resident).
Census

✓ Single intern teams have an educational limit of 14 patients
  a. The maximum number of patient encounters a single intern may see is 10 per RRC mandate.
✓ Double intern and manager teams have an educational limit of 16 – 18 patients.

Each team should attempt to reach the educational limit, but discretion of the attending based on team acuity and safety is permitted. The teams will admit all UMA patients. Residents may not refuse admissions. If the resident feels an admission is inappropriate, they must call the attending and the attending needs to evaluate the patient before deciding on admit vs. not admit.

Readmissions

If a patient has been admitted within the period of service of the current senior resident, the team should assume responsibility for this patient (bounce-back). In the event of a disagreement about who should admit a patient, contact your attending physician to decide or follow the instructions of the ER physician who has evaluated the patient.

Work Rounds

✓ Pre-rounds/Work rounds are to be conducted by the resident, intern(s), and medical student(s) prior to attending rounds.
✓ The senior is responsible for providing oversight of the interns on all patients on the census prior to attending rounds.
✓ Work rounds are primarily designed for the supervising resident to teach team members how to evaluate the clinical issues of the patient, plan the workup, and make appropriate treatment decisions.

Attending Teaching Rounds

✓ Rounds should begin most weekdays by 9 AM and break by 11 AM so residents can do work while still being able to attend mandatory conferences.
✓ The senior should have seen all patients on the census prior to attending rounds.
✓ EMR notes should be completed by the resident no later than 2 PM.
✓ On post-call weekends (post Fri/Sat) night calls rounds must comply with duty hours.
✓ Management issues may be discussed in conjunction with didactics.
✓ Teaching rounds are for the attending physician to be involved in the educational aspects of the cases and to appropriately supervise the clinical care of team patients.

Consultations

✓ Consults should be called by the intern/resident.
✓ 3rd year medical students should not call in consults.
✓ Junior Interns (JI) may call consults only if senior resident is physically present with the JI.
✓ If there is a resident on the service that is being consulted, please communicate directly with the resident on the service. A written consult order is still required.
✓ Interns should speak with their senior prior to calling a consult.
If an intern is called to accept a consult, please discuss with your senior and have them return the call to the attending requesting the consult.

When consulting other specialties, the consulting physician is expected to make recommendations and permit the primary resident to write orders unless the order is urgent or emergent.

**Transfers from Outside facilities**

- Return call to the bed desk in a timely fashion. Only accept patients from outside facilities through the bed desk. If a physician calls you directly without notifying the bed desk, please have them call 778-8100, so you will be on a recorded line.
- Only the senior resident or attending can talk to the transferring physician to accept a transfer.
- Usually all floor transfers are accepted. We do not accept ICU direct admission (outside MDs must discuss with Critical Care attending first), pregnant patients, or patients under 18 years old. If you feel that the patient being transferred is too sick for 3000 Medicine (formerly HFMU) or should not be admitted to our service for any reason, do not refuse transfer but take down patient information and tell the transferring attending you must first discuss the patient with your attending before acceptance.
- Remember that all calls are recorded.
- Ask all relevant historical and clinical information: demographics, pertinent medical history, exam findings/VS/labs/diagnostic studies/imaging. Is patient stable for transfer to a regular bed?
- Ask for documentation to be sent with the patient and images be pushed to PACS, if relevant.
- Ask the bed desk/EROC if they know the patient’s room number. Tell them the name of the attending that it is to be admitted under and to page 8000 immediately on arrival for all remaining orders.
- If a resident does not have adequate time to fully assess the patient before the end of the shift, please still “lay eyes” on the patient to ensure stability and time permitting, write basic orders for immediate needs and handover to oncoming call team. If you have not been notified of patient’s arrival by handover or within 4 hours after accepting please call the bed desk or floor and confirm that the patient has not arrived.
- As always, please call attending-on-call if you have any questions or are uncertain about something.
- If the requesting physician is asking for required consultant services please bring the consultant into the call for coordination of admission. Do not accept a subspecialty admission without confirming with the consulting service.

**INCIDENT/OCCURRENCE REPORTING (E-SAFE)**

Patient safety and quality improvement are of paramount importance in Internal Medicine. If there is a patient care situation that is a near miss, error, or system issue that negatively impacts patient care please submit a report via the Erlanger e-Safe Occurrence and Complaint Reporting system. The link is available on the Erlanger Intranet Home page (from an Erlanger computer or through the Physician Portal) on the Application Link on the right hand menu area. Use your Erlanger computer network login and password to access. Your attending or the nursing supervisor may assist you in doing this. Please always discuss these cases with your attending.
MEDICAL RECORD COMPLETION POLICY

Inpatient Rotations

- All H&Ps need to be completed the day of admission.
- Discharge Summaries should be completed the same day and should not exceed 24 hours.
- Discharge summaries need to be completed on all patients admitted to the hospital, including those admitted for 23-hour observation.
- All records need to be signed in a timely manner.
- Any records exceeding 7 days are delinquent.
- Records exceeding 14 days will require action by the department.
Continuity Clinic

- Notes should be completed prior to leaving clinic.
- Inboxes need to be checked daily even while on other rotations outside of the clinic week assignment.

Discharge Summaries

All patients discharged to nursing homes or other medical facilities must have a completed discharge summary to accompany the patient. All other discharge summaries (patients discharged to home) must be dictated within 24 hours of discharge, and preferably on the day of discharge. Be sure to “CC” the patient’s primary care provider, or the physician that the patient will be following up with, at the end of your dictation. All patients require a discharge summary, including those admitted for 23-hour observation.

BACKUP COVERAGE SYSTEM (AKA “JEOPARDY SYSTEM”)

The backup coverage system for vital clinical service roles termed historically as the jeopardy system exists to provide back-up for residents who find themselves unexpectedly unable to work their assigned rotation due to illness or personal emergency. Jeopardy system structure and rules:

1. Be professional, responsible and conscientious
   - This system is to be used ONLY when absolutely needed for sickness or personal emergency, so please use it responsibly.
   - Please do not abuse this jeopardy system and be mindful of your co-residents time and life.
   - Any abuse to the system will not be tolerated and will have consequences.

2. The person assigned to jeopardy must be available 24 hours a day for the duration of their jeopardy coverage. That means:
   - Able to make it to the hospital within 1 hour, preferably stay in town.
   - Make sure your cell phone and pager are on and working 24/7.
   - Be professional and responsible (sober and able to work).
   - Failure to answer jeopardy call is a breach to professionalism and has consequences (listed below).

3. Coverage
   - Interns will cover their co-interns, and seniors (2nd and 3rd years) will cover each other.
   - There will be a senior on First Call, a senior on Second Call, and an intern on First Call.
   - If more than one intern coverage was needed then coverage will be done as follows: intern on First Call then senior on First Call then senior on Second Call.
   - Senior coverage: senior on First Call then senior on Second Call.
   - If senior on First call was already covering for an intern and a senior coverage was needed then senior on Second Call will cover.
   - If more coverage was needed at any given time, we will call other residents to cover as we see fit and appropriate based on schedule and availability.
4. Jeopardy call process:
   1. Call the Chief Resident to inform him/her of inability to work and reason.
      - You must CALL. Text messages and emails are not acceptable.
      - You must call before your scheduled shift. Please do not wait until your shift has already started.
      - Informing the Chief of absence from work after the work shift is done is not acceptable and will be considered a breach of professionalism.
   2. Chief will call the intern or senior on First Call
      - You will be called on your cell phone first (please make sure it’s working 24/7)
      - If cell phone was not answered, you will receive a call to your pager
      - You have 15 minutes to answer the jeopardy call. Failure to answer a jeopardy call within this time is a breach to professionalism.
   3. If First Call intern/senior did not answer or a 2nd coverage is needed, Chief will call senior on Second Call.
      - Same procedure will apply. Intern/senior on Second Call will be contacted on cell phone then pager. Failure to respond within 15 minutes is a breach to professionalism.

5. Consequences
   - Any breach of professionalism by failure to answer jeopardy calls, not reporting to the assigned work shift, refusing to report the assigned work shift, and others will have serious consequences.
   - Consequences can include but limited to: assignment of extra jeopardy call coverage to be determined by the program administration.

6. Jeopardy Exchanges
   - Interns:
     - You can switch with any other intern either on consult or clinic.
   - Seniors:
     - You can only switch on a consult time. Switching from jeopardy on consult to jeopardy on clinic will not be accepted.
     - You should switch a First Call with a First Call and Second Call with a Second Call. If someone agrees to switch to a different call order with you, that will be okay.
   - Interns don’t have a lot of time on consult so their exchanges are more flexible. Seniors, you have a lot of consult time and you’re expected to make an exchange of jeopardy happen on consult time only.
   - It’s your job to find someone to switch jeopardy time with you. When you find someone agreeable to switch, email me with the following:
     - Your name and jeopardy time.
     - Other resident name and his jeopardy time.
     - You have to CC other resident in email to ensure he agrees to the exchange.
DIDACTIC CONFERENCES

- The program produces a monthly schedule which is distributed to all residents and faculty.
- Required conferences include: case (“morning”) report, educational content conferences, journal club, patient safety conferences (M&M), weekly continuity clinic and PSQI conferences during ambulatory week and grand rounds.
- Please be respectful of the presenter and be on time.
- Residents are expected to attend all conferences when on rotations during the day in the hospital unless an unstable patient requires attention.
- Residents on night float, scheduled off-days, vacation, and off-site rotations are not expected to be present, but all others should be in attendance.
- Residents are responsible for the accuracy of any and all conference sign-in logs.
- Signing in for days not attended or for other residents is unethical and unprofessional and will result in disciplinary action.

Case Presentations (aka Resident or “Morning/Afternoon Report”)

- Not a lecture.
- Interns may help with the case presentation, but **THIS is primarily the senior resident’s responsibility**.
- A PowerPoint presentation is not required.
- Present the history first (HPI, PMH, SH, FH social) then open the floor for questions.
- The differential diagnosis (use a systematic approach) should include at least three to five items.
- After the history is obtained and DDx is developed, you may move to PE, labs, imaging or other diagnostic studies to further rule in or rule out DDx items.
- Discussion of the diagnosis and patient management should be clearly stated.
- Explicitly state 2 or 3 teaching or take home points.
- Discuss the case with the chief resident before the presentation (timeframe dictated by chief resident).

YALE OFFICE BASED MEDICINE CURRICULUM LOGIN INFORMATION

The program is now utilizing the Office Based Medicine Curriculum authored by Yale University ([https://medicine.yale.edu/intmed/obm/](https://medicine.yale.edu/intmed/obm/)) during ambulatory clinic weeks.

Login information for our program is:

Username: Chattanooga
Resident password: soybean
MOONLIGHTING

- Interns are not allowed to moonlight.
- PGY2 and PGY3 residents desiring to moonlight must notify and have written permission from the program director prior to moonlighting.
- Those upper level residents below the 30th percentile on the ITE will not be permitted to moonlight.
- The departmental request form included at the end of this manual must be submitted prior to the scheduled activity.
- All residents desiring to moonlight must obtain a Tennessee Medical license and malpractice insurance coverage for any professional work outside of residency activities. The Tennessee State Claims Commission, which provides immunity from professional liability for residents when functioning as a resident in our GME Programs and when acting within their training responsibilities, does not provide malpractice coverage for moonlighting activities.
- Moonlighting schedules must be logged on New Innovations within 24 hours of doing the activity.
- No moonlighting is allowed during any inpatient rotation.
- Moonlighting hours must be logged into New Innovations and total duty hours (residency shifts + moonlighting) may NOT exceed 80 hours per week.
- Moonlighting schedules should not interfere with your regular duties. Residents should not leave their rotation site early or before their duties are completed in order to begin a moonlighting shift.
- Moonlighting must not interfere with meeting the requirement of having at least 8 hours between work assignments.
- Failure to comply with the above or marginal-to-unsatisfactory evaluations will result in loss of moonlighting privileges. See the GME Moonlighting Policy via the below link.
- Failure to comply with the above or marginal-to-unsatisfactory evaluations will result in loss of moonlighting privileges.

PHARMACEUTICAL COMPANY SPONSORSHIP OF LUNCHES/DINNERS FOR RESIDENTS

Pharmaceutical representatives are not allowed to participate in residency activities. The Department of Medicine strongly discourages resident attendance at pharmaceutical company sponsored dinners as studies have shown that physicians do not detect the inaccuracies in presentations. A substantial literature has developed illustrating that pharmaceutical presentations alter physician prescribing towards more expensive branded medications instead of generic products and national guidelines. No announcements, promotions, or arrangements for industry-sponsored activities can occur at resident conferences.

MEDICAL STUDENTS

Dr. Patick Koo is the clerkship director. He will ultimately dictate student requirements. The points below are precedent from years past but are subject to change at any time by the clerkship director. If a concern arises regarding student performance or professionalism, this should be brought to the attention of the Clerkship Director immediately.

Third Year Medical Students on Inpatient General Medicine Teams are:

- Primarily supervised by one of the team’s interns.
To be assigned 1–2 new patients per call.
To carry a minimum of 2 patients and up to a max of 5.
To perform comprehensive history and physical examinations with a complete assessment and plan for each problem.
Expected to write daily progress notes on all of their patients without exception. Student notes do not count at this time for billing purposes. Full notes must still be completed by interns (on M3) and seniors (on M4s).
Expected to pre-round on their patients and present during work and attending rounds.
To review and practice oral presentations days prior to rounds.
To have at least 2 SOAP notes evaluated and corrected by the resident.
 Asked to present a 5-10 minute topic assigned by the resident reflecting a relevant clinical management issue which may come up on rounds. One to two presentations a week is the expectation. Students will give you a student presentation evaluation sheet which you must fill out and turn back to the student.
To complete documentation ASAP (within 4 hours) and it must be cosigned by the resident.
To receive feedback daily. Mid-clerkship evaluations are required from both the attending and resident.

Fourth Year Medical Students on Inpatient General Medicine Teams – Junior Interns (JI) should:

- Function as interns and be directly supervised by the senior resident (not interns).
- Have orders written on all of his/her patients which are then co-signed by the resident.
- Admit patients regularly and should follow up to 5 patients at a time.
- Follow resident duty hour rules.
- Receive timely feedback that occurs daily and must have a written mid-rotation evaluation.

PATIENT ASSIGNMENTS

Continuity Clinic

During ambulatory assignments, patient visits for residents should average:

- PGY 1: 3 to 5
- PGY 2: 4 to 6
- PGY 3: 6 to 8

Each resident must have a total of 130 clinic sessions over the three years of training.

Inpatient Medicine

- A first-year resident must not be responsible for more than five new patients per admitting day.
- A first-year resident must not be assigned more than eight new patient admissions in a 48-hour period.
- A first-year resident must not be responsible for the ongoing care of more than 10 patients during inpatient ward medicine as well as subspecialty rotations.
• When supervising more than one first-year resident, the second- or third-year resident must not be responsible for the ongoing care of more than 18 patients.

• The second-year or third-year resident must not be responsible for admitting more than a total of 10 new patients per admitting day or more than 16 new patients in a 48 hour period, including the first-year resident’s patients being supervised.

**Consult Services**

• The numbers of admissions are not specified and the supervising attending will monitor and set parameters for resident participation in the service.

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**DEATH REVIEWS**

Residents should attempt to obtain autopsies for all unexpected deaths and may attend autopsies performed on their patients. When you are requesting an autopsy always discuss the case with your supervising attending first. The procedure to request an autopsy can be assisted by A1 (administrator-on-call). Residents should be notified when the autopsy is to be performed. The final autopsy report is to be sent to the Department of Medicine for distribution to the residents caring for the patient. Also, the report can be accessed on the Erlanger Net Access report under the Pathology section.

**Team Deaths and Patient Safety Conference (Morbidity and Mortality) Conference**

All team deaths must be recorded and reviewed with the team at the end of the rotation. One case should be fully discussed during a patient safety conference. The presentation should be case-based, interactive, provide take-home or teaching points that are evidence-based. Additionally, root cause analysis discussion regarding errors should occur and focus on how to prevent same error from occurring again. Patient safety conferences are non-punitive and are opportunities for the residency program to help us to identify system errors to help improve medical care in our community and health care system.

**Death Certificates**

Please notify the appropriate team attending of any team death immediately (call or tiger text) so the TN state death certificate can be completed in a timely manner. Delay of death certificate completion can prevent families from accessing insurance money, bank accounts, paying bills etc. which can cause an undue financial burden for the patient’s family.

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**ACLS CODE COMPETENCY**

Internal Medicine PGY 2 and PGY 3 residents are responsible for leading codes throughout the hospital (with the exception of the closed ICUs). In preparation for this, rising PGY2 will be scheduled for an "ACLS check off", as well as mandatory meet and greets with core members of the code team ("Red Shirts"). The "ACLS Check off" consists of a code simulation on a high fidelity mannequin lead by the rising PGY2. The resident will perform the simulation on their own, with faculty members acting as ancillary staff. Residents are graded with a competency evaluation made up of core ACLS skills based upon the American Heart Association certification parameters as determined by the faculty members involved in the simulation. A passing score is considered 12 out of 15 points.
on the skills evaluation. Any resident who has not passed has the opportunity to have one on one faculty coaching on ACLS skills before performing the check off simulation activity again.

**PROGRAM EVALUATION COMMITTEE (PEC)**

The PEC is responsible for the planning, developing, implementing, and evaluating educational activities of the program. The committee reviews and makes recommendations for revision of competency-based curriculum goals and objectives and addresses areas of non-compliance with ACGME standards. The group will review the program annually using evaluations of faculty, residents, and others. The program, through the PEC, will document a formal systematic evaluation of the curriculum annually. The committee will render a written annual program evaluation.

Members include the program director, associate program director, program coordinator, core clinical faculty, division chiefs, rotation directors and all residents.

The program must monitor and track each of the following areas:

- **Resident performance**
  - including outcome assessment of the educational effectiveness of inpatient and ambulatory teaching (*i.e.*, In-Training Exam results)

- **Faculty development**

- **Graduate performance**
  - At least 80% of those completing their training in the program for the most recently defined three-year period must have taken the certifying examination
  - A program’s graduates must achieve a pass rate on the certifying examination of the ABIM of at least 80% for first-time takers of the examination in the most recently defined three-year period

- **Program Quality**
  - Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually
  - The program must use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program

- **Monitor progress on the previous year’s action plan**
  - The ability to retain qualified residents by graduating at least 80% of its entering categorical residents averaged over the most recent three-year period

The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in the section, as well as delineate how they will be measured and monitored.
The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes

- The department should share appropriate inpatient and outpatient faculty performance data with the program director.
- The program must organize representative program personnel, at a minimum to include the program director, representative faculty, and one resident, to review program goals and objectives, and the effectiveness with which they are achieved.

Committee Composition for 2020 – 2021:

- Chair: Curtis Cary (PD)
- Faculty Members:
  - Louis Lambiase (Department Chair)
  - Mike Davis (Global/Community Health Track Director)
  - Radhika Shah (APD)
  - Jarle Stone (Chief Resident)
  - Laura Youngblood (General Internal Medicine Division Chief)
  - Maria Tudor (Curriculum)
  - Deborah Fuller (Coordinator)
  - Patrick Koo (Medical Student Clerkship Director)
  - Jensen Hyde (Inpatient Medicine)
  - Jigme Sethi (Pulm/CC Division Chief)
  - Aaron Cohen (Pulm/CC Rotation Director)
  - Jeremy Greenberg (Pulm/CC Rotation Director)
  - Harish Manyam (Cardiology Division Chief)
  - Dharmendra Patel (Cardiology Rotation Director)
  - Matt Graham (Heme/Onc Division Chief)
  - Michael Brit (Rheumatology Division Chief)
  - James Sizemore (ID Division Chief)
  - Jon Cohen (Psychiatry)
  - Christopher Poole (Nephrology Division Chief)
  - Arslan Kahloon (GI Division Chief and Rotation Director)
  - Nick Pumilia (UMA)
  - Gary Malakoff (UMA)
  - Eric McCartt (Hospital Medicine)
- Resident Members:
  - ALL (n=31)

PROGRAM EVALUATION

The residency program values the input of residents and faculty alike to continually improve the quality of the residency training program. Each year the residency program undergoes a thorough evaluation of all aspects of resident education. All residents and faculty will receive an anonymous survey to provide feedback and voice
concerns about any element of the residency training program. In a subsequent meeting of faculty and residents, the surveys and any other information relevant to the residency training program will be reviewed. The product of this meeting will be an overall assessment of the program as well as an action list of important elements of the program that can be enhanced.

The program evaluation will consider the following –

1. Anonymous Resident Program Evaluation of:
   - Didactics conferences/curriculum
   - Rotation goals and objectives and evaluations
   - Curriculum as a whole
   - Educational value of each participating institution
   - Quality of supervision

2. Anonymous Faculty Program Evaluation of:
   - Strengths of and areas of improvement concerning:
     i. Residents
     ii. Rotations
     iii. Faculty
     iv. Continuity Clinic
     v. Education

3. Duty Hours monitoring results

4. ABIM board pass rates

5. ACP In-training Examination performance

6. Most recent ACGME Site Visit Letter

7. Most recent ACGME Resident Survey results

8. Most recent Program Internal Review Report

**PROFESSIONALISM**

The University Of Tennessee College Of Medicine Chattanooga Internal Medicine Residency Program expects all residents to abide by the professionalism and ethical behavior tenets established in two separate documents:

1. University of Tennessee College of Medicine Chattanooga Internal Medicine Residency Program Guidelines

2. University of Tennessee College of Medicine Chattanooga GME Institutional Policy

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE CHATTANOOGA INSTITUTIONAL REQUIREMENTS**
It is the policy of the University Of Tennessee College Of Medicine Chattanooga (UTCOM Chattanooga) to treat all individuals within the Erlanger Health System or any other facility in which patient care and/or training is being conducted, with courtesy, respect, and dignity. To that end, the UTCOM Chattanooga requires that all individuals (Faculty, Residents*, Medical Students, and staff) conduct themselves in a professional and cooperative manner. It is also the policy of UTCOM Chattanooga to be sensitive to a practitioner’s health or condition that may adversely affect that individual’s ability to provide safe, competent care to his or her patients. The concern is for high-quality patient care always, but it is accompanied by compassion for the practitioner whose abilities may be diminished in some way due to age, medical illness, substance abuse, impairment, or disruptive behavior. It is the responsibility of the UTCOM Chattanooga to investigate and respond to unprofessional, impaired or disruptive behaviors.

Definitions:

Impairment – A change in the health status of an individual that jeopardizes the practitioner’s ability to carry out his or her delineated privileges with good quality. Examples may include but not be limited to:

- Stress
- Burnout
- Deterioration through the aging process
- Loss of motor skills

Acute Impairment – May be derived from substance abuse/dependence, physiological, emotional, or psychological difficulty and may be evidenced by a variety of behaviors or other observations not limited to a single event or episode.

Disruptive Behavior – Exhibitions of a pattern of behavior characterized by one or more of the following actions:

- Use of threatening or abusive language directed at nurses, hospital personnel or other physicians.
- Use of degrading or demeaning comments regarding patients, families, nurses, physicians, hospital personnel, or the hospital.
- Use of profanity or other grossly offensive language while in a professional setting.
- Use of threatening or intimidating physical contact.
- Making public derogatory comments about the quality of care being provided by other physicians, nursing personnel, or the hospital, rather than working through the peer review process or other avenues to address these issues.
- Writing inappropriate medical records entries concerning the quality of care provided by the hospital or any individual.
University of Tennessee College of Medicine Chattanooga Internal Medicine Residency Program
Program Director Approval Form for Academic Year 2020 – 2021

Effective ___________, permission is granted for _________________________________________________ to moonlight through June 30, 2021 for (company or institution):

Name of Moonlighting Activity:
Address of Moonlighting Activity:
Telephone Number for Moonlighting Activity:

(Initial all)
_____ Moonlighting is not a requirement of internal medicine residency training.

_____ All moonlighting activities must be in compliance with ACGME requirements for duty hours:

External Moonlighting
• All clinical and academic activity (including moonlighting) must be limited to 80 hours per week, averaged over a 4-week period.

Internal Moonlighting
• All clinical and academic activity (including moonlighting) must be limited to 80 hours per week, averaged over a 4-week period.
• You are prohibited from participating in any patient care activities (including moonlighting) after 24-hours of continuous duty.
• All in-house on call activities consisting of 24 hours of continuous duty must be followed by a 14-hour rest period in which there are no clinical, administrative, educational activities or moonlighting.

_____ Residents must track their moonlighting hours monthly in New Innovations and assure compliance with ACGME requirements.

_____ Moonlighting must never interfere with the goals and objectives of the residency program.
• You are not to leave duties early, arrive late, alter your team's rounding schedule, or fail to perform any of your duties as a result of your moonlighting activities.
• You may not be on call (even home call or on the “pull list”) and simultaneously moonlight.

_____ Violations of these guidelines will result in you being brought before the Clinical Competency Committee and may result in the summary termination of your appointment.

Larry Curtis Cary, MD, FAAP, FACP, AAHIVS
Internal Medicine Program Director

Program Director Signature: X__________________________

Resident Name: ________________________________

Resident Signature: X__________________________

Robert Fore, EdD, FACEHP, CHCP
Designated Institutional Officer (DIO)

DIO Signature: X__________________________
APPENDIX B: RESEARCH ELECTIVE FORM

University of Tennessee College of Medicine Chattanooga
Internal Medicine Residency Program Research Rotation Form

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>PGY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates of Elective:</td>
<td></td>
</tr>
<tr>
<td>Description of Experience:</td>
<td></td>
</tr>
<tr>
<td>Provide a brief description of activity:</td>
<td></td>
</tr>
<tr>
<td>Goals: What do you hope to achieve during this elective experience (minimum of 2)?</td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td>Faculty Preceptor(s):</td>
<td></td>
</tr>
<tr>
<td>Who has agreed to supervise the learning experience &amp; complete your evaluation?</td>
<td></td>
</tr>
<tr>
<td>Preceptor Department or Division:</td>
<td></td>
</tr>
</tbody>
</table>

Fill in your anticipated weekly schedule. Include all proposed elective activities and location.

<table>
<thead>
<tr>
<th></th>
<th>MON</th>
<th>TUES</th>
<th>WED</th>
<th>THURS</th>
<th>FRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(12-1:30)</td>
<td>← ATTENDANCE TO CONFERENCE REQUIRED UNLESS EXCUSED →</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Approved: ___________________________ Date: ___________________________
  Research Rotation Faculty Mentor

Approved: ___________________________ Date: ___________________________
  Internal Medicine Residency Program Director Signature
# APPENDIX C: INPATIENT DIRECT OBSERVATION FORM

<table>
<thead>
<tr>
<th>Evaluator Name:</th>
<th>Resident Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Patient Problem/Dx:**

<table>
<thead>
<tr>
<th>Setting</th>
<th>Age</th>
<th>Sex</th>
<th>Complexity</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>Other: (specify below)</td>
<td>Female</td>
<td>Low</td>
<td>Data gathering</td>
</tr>
<tr>
<td>Critical Care</td>
<td></td>
<td>Male</td>
<td>Moderate</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>General Medicine Wards</td>
<td></td>
<td></td>
<td>High</td>
<td>Therapy</td>
</tr>
</tbody>
</table>

## EVALUATION

Circle or place an “X” on the number that corresponds to your evaluation rating

### Criteria/Rating

<table>
<thead>
<tr>
<th>Criteria/Rating</th>
<th>DID NOT OBSERVED</th>
<th>UNSATISFACTORY</th>
<th>SATISFACTORY</th>
<th>EXCELLENT</th>
<th>SUPERIOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Medical Interview Skills</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2 Physical Examination Skills</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3 Humanistic Qualities &amp; Professionalism</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4 Clinical Judgment</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5 Counseling Skills</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6 Organization/Efficiency</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7 Overall Clinical Competence</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### How much time did you spend on the evaluation? How many minutes did you observe? How many minutes did you provide feedback?

### How satisfied are you with this Mini-CEX? How satisfied are you with this Mini-CEX?

<table>
<thead>
<tr>
<th>Evaluator</th>
<th>Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW 1 2 3 4 5 6 7 8 9 10</td>
<td>LOW 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>HIGH</td>
<td>HIGH</td>
</tr>
</tbody>
</table>

### Comments (continue on other side if needed)

- **Evaluator Signature:**
- **Resident Signature:**

## DESCRIPTORS OF COMPETENCIES DEMONSTRATED DURING THE DIRECT OBSERVATION/MINI-CEX

**Medical Interviewing Skills:** Facilitates patient’s telling of story; effectively uses questions/directions to obtain accurate, adequate information needed; responds appropriately to affect, non-verbal cues.

**Physical Examination Skills:** Follows efficient, logical sequence; balances screening/diagnostic steps for problem; informs patient; sensitive to patient’s comfort, modesty.

**Humanistic Qualities/Professionalism:** Shows respect, compassion, empathy, establishes trust; attends to patient’s needs of comfort, modesty, confidentiality, information.

**Clinical Judgment:** Selectively orders/perform appropriate diagnostic studies, considers risks, benefits

**Counseling Skills:** Explains rationale for test/treatment, obtains patient’s consent, educates/counsels regarding management.

**Organization/Efficiency:** Prioritizes; is timely; succinct.

**Overall Clinical Competence:** Demonstrates judgment, synthesis, caring, effectiveness, and efficiency.

---

**Note 1:** Reprinted with permission from the American Board of Internal Medicine, [www.abim.org](http://www.abim.org).

### APPENDIX D: OUTPATIENT MEDICINE DIRECT OBSERVATION FORM

<table>
<thead>
<tr>
<th>Resident:</th>
<th>Attending:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Age:</td>
<td>☐ New ☐ Follow-up ☐ Preventive Healthcare</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History-Taking:</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Satisfactory</th>
<th>Superior</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Obtain a relevant and pertinent history</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Respond to patient/parent concerns and cues during the encounter</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Complete a relevant and pertinent physical exam</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Management:</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Satisfactory</th>
<th>Superior</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Effectively explain the management plan to the patient without medical jargon</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Include the patient in medical decision-making</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Management plan reflects cost awareness and risk-benefit analysis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient/Family Education:</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Satisfactory</th>
<th>Superior</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Effectively counsel patient/parent regarding health promotion and disease prevention</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. Actively assist patient/parent in dealing with system complexities</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professionalism:</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Satisfactory</th>
<th>Superior</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Behave in a sympathetic and caring manner toward the patient/parent</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10. Demonstrate sensitivity toward the patient’s/parent’s background</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Resident Reflection on Patient Encounter (How do you think the visit went?):

Attending Comments:

Resident Signature

Attending Signature
APPENDIX E: HANDOVER EVALUATION FORM

Faculty Evaluator Name: ________________________________  Evaluation Date: ________________

Resident Name: ____________________________________  # of patients handed off: ______

### Setting/Situational Overview

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the room sufficiently quiet with minimal distractions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was a situational overview provided by the resident giving the handoff (e.g. description of the “big picture” of what will need to be prioritized by the receiver of the handoff)?</td>
<td>Yes</td>
<td>NO</td>
</tr>
</tbody>
</table>

### Rate the frequency (checking the appropriate column below) with which the resident who gave the handoff did the following (IPASS):

<table>
<thead>
<tr>
<th>Description</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Fairly Often</th>
<th>Very Often</th>
<th>Unable to Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness Severity (I)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Summary (P)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief hospital course, new/recent events, overall clinical status using the standardized patient summary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Plan (A)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task list for overnight complete with plan (i.e. if hemoglobin below 7, transfuse 1 unit PREC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situation Awareness/Contingency Planning (S)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticipate upcoming possibilities and provide anticipatory guidance (“if X then Y” statements)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures synthesis by receiver (S)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actively engages receiver to ensure shared understanding of patients (Encouraged questions, checks for understanding)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triage/Prioritize</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriately prioritizes key information, concerns, or actions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Rate the frequency with which the resident who gave the handoff did the following:

<table>
<thead>
<tr>
<th>Miscommunications or transfer of erroneous information</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Fairly Often</th>
<th>Very Often</th>
<th>Unable to Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omissions of important information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tangential or unrelated conversations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Rate the written handoff (EPIC Handover Tool):

<table>
<thead>
<tr>
<th>Was the information in the written handoff UPDATED and ACCURATE?</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Fairly Often</th>
<th>Very Often</th>
<th>Unable to Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were there omissions of key information from the written handoff?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Rate the overall impression of the pace of the handoff (circle one):

<table>
<thead>
<tr>
<th>Very slow &amp; Very inefficient</th>
<th>Slow and inefficient</th>
<th>Optimally paced</th>
<th>Efficient Not rushed</th>
<th>Fast and Pressured</th>
<th>Very Fast &amp; Very Pressured</th>
</tr>
</thead>
</table>

### Overall feedback (what was good about the handoff, what areas could the resident work to improve?)

[Blank]

Attempt # _________  Pass (Y/N)? _________  Attending Signature ____________________________

**Note:** If there is a check in any shaded box, the intern is not yet proficient in the skill and therefore will require further practice and re-evaluation.
Dear Patient,

Please give us feedback about your doctor visit today.

Circle the number that corresponds to your answer for each question on this survey.

Your responses are entirely confidential.

Thank you for your time. Your responses are valuable to us!

Please rate how well your doctor did in the following areas:

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listened to what you had to say?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Showed concern for your questions and worries?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Explained your health/condition in words you could understand?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Explained medications and tests?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Included you in decisions about your treatment?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Was friendly and caring?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Washed their hands or used hand sanitizer (circle one)?

- Yes
- No

Comments:
APPENDIX G: STAFF GLOBAL ASSESSMENT FORM

Resident: ____________________________________________  PGY Level (circle):  1  2  3  Date: ___/___/_____

Please check the column that best describes this resident’s performance in each performance item.

It is helpful to include comments that explain your answers in order to give this resident constructive feedback.

<table>
<thead>
<tr>
<th>Performance Areas</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Meets Expectation</th>
<th>Exceeds expectations</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attends to patient’s comfort and understanding during visit and any procedures performed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receptive and uses feedback from staff to improve patient care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicates with staff in a manner that is both effective and respectful.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates sensitivity to a diverse patient population.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actively listens to patient and staff concerns.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaves in a sympathetic and caring manner with patients and families.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respond to questions in a timely manner.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effectively coordinate patient care by taking into account input from all team members.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
## APPENDIX H: ACLS CODE COMPETENCY CHECKLIST

UT Erlanger Internal Medicine ACLS Competency Checklist

Name ________________________    Simulation Date _____________    PGY Level _____    Observer________________

<table>
<thead>
<tr>
<th>Skill</th>
<th>Performed?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team Leader</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assign roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures high quality CPR</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VF/VT Arrest</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognize rhythm – Stable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognize rhythm - Unstable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear before analyze and shock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediately resume chest compressions after shock</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Appropriate management of airway</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Appropriate cycles with drugs, shocks, and chest compressions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Administer appropriate drugs and doses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Asystole and PEA management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognize PEA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognize asystole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbalize reversible causes of PEA arrest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediately resume chest compressions after rhythm check</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Post Cardiac Arrest Management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognize ROSC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check vitals and order labs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score ________

For passing, requires 12 out of 15 points.
## APPENDIX I: INTERPROFESSIONAL EVALUATION FORM

Please provide any examples that pertain to the descriptions below for any of the listed milestone assessments for the medical resident, Dr. _________________. Pictures of the internal medicine resident physicians can be found at: [http://comchattanooga.uthsc.edu/subpage.php?pageId=577](http://comchattanooga.uthsc.edu/subpage.php?pageId=577).

<table>
<thead>
<tr>
<th>Often times, factors beyond the acute medical illness affect patient care. Please provide examples of how the resident recognized the role of income, social support, and behavioral factors on the patient’s care (MK1):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Please describe how the resident involved your specialty in the decision making for the patient’s care (SBP1):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Please provide examples of how the resident identified opportunities to prevent or respond to error for a particular patient or within the healthcare system (SBP2):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Describe how the resident limited unnecessary cost through mechanisms such as – use of generic or formulary alternative medications, drug assistance programs, avoidance of unnecessary testing and treatment, or avoiding emergency room care for patients experiencing acute illnesses that can be managed as an outpatient (SBP3):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Please provide examples of the resident’s skill(s) at transitioning patients between hospital units as well as to home. This may relate to medication reconciliation, consideration of future care, or navigation of safe-discharge barriers such as transportation, ability to purchase medications, home living environment, language/cognitive barriers, or social support (SBP4):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Please describe when you gave feedback to the resident in terms of their openness and acceptance, and if you noticed they reflected on your comments and made changes leading to improvement (PBLI3):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
</tr>
<tr>
<td>Summarize ways you found the resident displayed empathy and advocated for their patients, noting the resident’s respectful, professional, and compassionate interactions (PROF1):</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Examples:</td>
</tr>
<tr>
<td>Please provide examples of how the resident was (or wasn’t) timely in the completion of tasks you requested. Please comment if the resident needed multiple reminders (PROF2):</td>
</tr>
<tr>
<td>Examples:</td>
</tr>
<tr>
<td>Please comment on specific times you noticed the resident considered the patient’s culture, beliefs, impact of their illness, etc. in the patient’s plan of care (PROF3):</td>
</tr>
<tr>
<td>Examples:</td>
</tr>
<tr>
<td>Please state if the resident was (or wasn’t) approachable, collaborative, and/or accepting of your input to the care of the patient (ICS2):</td>
</tr>
<tr>
<td>Examples:</td>
</tr>
<tr>
<td>Please feel free to provide any additional comments you think are germane to the aspects of this assessment instrument:</td>
</tr>
</tbody>
</table>
APPENDIX J: CURRENT LEAVE FORM (NOTE FORM COLOR OF GREEN)

FORM IS PURPLE FOR THE 2020 – 2021 ACADEMIC YEAR

HOUSESTAFF LEAVE REQUEST FORM

NAME: ____________________________

ROTATION: ________________________

DATES REQUESTED: ________________________

CHECK ONE:  

- VACATION (total 15 week days)*  
- CME (total 5 days) (attach copy of brochure)*  
- PERSONAL DAYS (total 5 days)  
- SICK  
- OTHER (specify) ____________________________

COVERAGE: Who will cover for you?

UMA/DESKTOP:  

(Print)  

(Signature)**

ROTATION: (If Applicable)  

(Print)  

(Signature)**

PROGRAM COORDINATOR  

APPROVED ____________________________

DENIED ____________________________

APPROVED-ATTENDING (If Applicable) ____________________________

APPROVED-MEDICINE CLINIC (If Applicable) ____________________________

*Must be submitted by June 1, 2020  
**Must be signed by resident providing coverage

SUBMIT COMPLETED FORM TO PROGRAM COORDINATOR FOR APPROVAL

Date Received: ____________________________

Revised 03/19
# APPENDIX K: CCC REVIEW DOCUMENTATION

<table>
<thead>
<tr>
<th>MILESTONES</th>
<th>Evaluations</th>
<th>Self-assessment</th>
<th>CCC FINAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT CARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gathers and synthesizes essential and accurate information to define each patient’s clinical problem(s). (PC1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develops and achieves comprehensive management plan for each patient. (PC2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manages patients with progressive responsibility and independence. (PC3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAL KNOWLEDGE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possesses the scientific, socioeconomic and behavioral knowledge required to provide care for common medical conditions and basic preventive care (MK1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of diagnostic testing and procedures. (MK2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SYSTEMS-BASED PRACTICE</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Works effectively within an interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and other support personnel). (SBP1)</td>
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<td>Recognizes system error and advocates for system improvement. (SPB2)</td>
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<td><strong>PRACTICE-BASED LEARNING AND IMPROVEMENT</strong></td>
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<td>Can translate medical information needs into well-formed clinical questions independently (PBLI4)</td>
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<td>Learns and improves via feedback. (PBLI3)</td>
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<tr>
<td><strong>PROFESSIONALISM</strong></td>
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<td>Has professional and respectful interactions with patients, caregivers and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel). (PROF1)</td>
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<td>Accepts responsibility and follows through on tasks. (PROF2)</td>
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<td>Exhibits integrity and ethical behavior in professional conduct. (PROF4)</td>
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<td><strong>INTERPERSONAL AND COMMUNICATION SKILLS</strong></td>
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<tr>
<td>Communicates effectively with patients and caregivers. (ICS1) and in interprofessional teams (e.g. peers, consultants, nursing, ancillary professionals and other support personnel). (ICS2)</td>
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<tr>
<td>Appropriate utilization and completion of health records. (ICS3)</td>
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**Evaluation sources:** (check all that apply)

- □ End of Rotation evaluations  □ Mentor documentation/opinion  □ PD evaluation
- □ Self-evaluation  □ Peer evaluations  □ Standardized test
- □ Other: __________________________________________________________________________

**CCC Assigned Member narrative:**

**CCC Group discussion narrative:**

**RECOMMENDATION TO PROGRAM DIRECTOR:**

The above mentioned resident has been reviewed by the Clinical Competencies committee on this date. The conclusion(s) and recommendation(s) from this group include:

**Overall assessment:** (mark all that apply)

- □ Below expected level  □ At expected level  □ Above expected level
- □ Ready for promotion  □ Ready for supervisory role  □ Needs remediation  □ Needs probation
- □ Immediate dismissal
- □ Other: __________________________________________________________________________

Is this resident on track to move to the next level of training?  □ Yes  □ No

**Action plan:** (mark all that apply)

**Meeting with:** □ Program Director  □ Mentor  □ Other (specified) ________________

To discuss:

Other:

Signature of Program Director: __________________________  Date: ______________

Signature of Resident: __________________________  Date: ______________
APPENDIX L: TEACHING 101 - TIPS FOR TEACHING MEDICAL STUDENTS

Asking Questions

Ask yourself do you want your learners to learn concepts or factoids? If its concepts, you should ask questions accordingly (i.e. don’t ask factoids). Similar to good interviewing skills, good teaching skills entails open-ended questions, so you can better assess your student’s and intern’s learning needs, to help them gain confidence in their knowledge as they answer your questions, and to help them reason to the correct answer, rather than “read my mind” questions or guess this esoteric questions. For example, let’s say a patient is admitted with hypertensive emergency, was placed on a nitroprusside drip, then weaned from that and now transferred to the floor.

---Example of a factoid question: “Prolonged administration of nitroprusside can result in what type of poisoning?” (Cyanide)
---Example of a pretty good open-ended question: “Can you tell me the difference between hypertensive emergency and hypertensive urgency?”
---Even better open-ended question: “Tell me what you know about hypertensive emergency?”

The reason the last one is better is that for the first two questions, they will need to recite a factoid (question 1) or for question 2, would need to have some concept of urgency vs. emergency to answer the question. For the third question, they can just tell you what they know, and this can allow you to know what to teach, and to prompt them to reason to an answer. For example, the student may know all about hypertensive emergency, and reciting their knowledge on rounds is a great confidence builder for them, and makes them a part of the team teaching. But say they say they don’t know about hypertensive emergency. Your teaching options now are to wax eloquent yourself, or better yet, force them to reason: “Well, let’s think...what would be an emergency situation with high blood pressure”; or if they are more novice: “Hypertensive emergency is a situation where there is end-organ damage from the high blood pressure. What are some organs which might be damaged? Yes, the heart, they may have a heart attack, what else? Yes, the brain.....” etc.

Fastballs

Early in the month your students and interns are often a little nervous and unsure. My first questions of the month, and usually my first questions each day, are relatively easy, to help them build confidence in answering questions in front of an audience (“Tell me what you know about heart failure”).

Limits

A common mistake for novice teachers is, that in their excitement to teach everything they know, they never let a teaching moment go by. Certainly powerful teaching moments need to not be missed, but the powerful ones are usually in the context of the patient (such as an intense discussion with a patient or family; or sometimes, explicit description of how you arrived at a clinical decision). However, many topics come up time and time again on the wards (CHF, PE, COPD, etc.), and each of these conditions only has so many teaching
points. There is no reason to drown rounds with too many teaching points – try to limit it to 5-10 major points per day at most.

**Plan**

Many approach teaching in a reactive fashion, the student or intern mentions something, a light bulb goes off as far as a question to ask in that situation, and so it goes. Certainly this reactor method is preferable to no teaching at all. But a risk of the reactor method is that you will drown rounds in too many facts, rounds won’t be efficient, and further, your teaching will be limited to what is mentioned by the student or intern – important topics won’t be broached. Better yet, you know the patients on your team ahead of time so plan ahead for at least some of the points you are going to make on next day’s rounds.

A corollary to this is planning prior to seeing a patient. For example, if your focus of teaching is doctor-patient communication, one can usually anticipate intense discussions before you walk into the room. Ask the students and residents how they want to approach this situation (say a patient who is ready for discharge, but is scared to leave the hospital). Then once discussed, model it (either you or your designee). AND THEN, reflect on what happened after the discussion, when you leave the room.

**Reflect Aloud**

To really make a teaching point stick, you need to reflect on what happened. You need to do this explicitly, aloud, so the students and interns can follow your reasoning and understanding. For example: “You see why we chose to empirically anticoagulate this patient with a suspected PE (until the CT or V/Q scan was finally done), he had all the risk factors for DVT...” ; or if things go bad: “Looking back, you need to reflect on your decisions, and this patient did have a GI bleed after we empirically anticoagulated him for PE, was this the right decision, ......”. We all reflect on medical decisions in our minds; for your learners, simply reflect aloud.

**Think Out Loud**

If you’re making a complicated decision (say, not to give or to discontinue antibiotics for a patient with fever but no obvious infectious source), think out loud your decision process. Even if the decision seems straightforward, check your learner’s understanding of the plan – “Do you understand why we’re getting an ERCP for this patient with jaundice?”

**It’s Okay to Say “I Don’t Know”**

No one knows everything, so don’t be fearful if you can’t answer all of your learner’s questions. By saying “I don’t know, but I’m going to learn about this...” (or better yet, why don’t WE all learn about this), you are not modeling inadequate knowledge, you are modeling lifelong learning.

**Teach Your Self**

The most lingering thing you will teach your students is yourself, the way you comport yourself, the way you ARE as a doctor and a person.
ACKNOWLEDGMENT OF MANUAL RECEIPT AND COMPREHENSION OF CONTENTS

I have received and read the Policies and Procedures and Graduation Requirements of the Department of Medicine. I understand the policy for advancement and graduation from the Residency Program.

___________________________________________
Signature

___________________________________________
Print Name

___________________________________________
Date

Please return by June 30, 2020.