The University of Tennessee
Health Science Center

College of Medicine
Chattanooga

INTERNAL MEDICINE RESIDENCY
PROGRAM GUIDELINES
2017-2018

Updated 6/29/2017
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Department Leadership and Administration

Chair, Department of Medicine: Louis Lambiase, MD
Program Director, Internal Medicine: Jennifer Dooley, MD
Associate Program Director: Mike Davis, MD
Program Director, Cardiology Fellowship: Alison Bailey, MD
Program Director, GI Fellowship: Louis Lambiase, MD
Medical Student Clerkship Director: Gary Malakoff, MD
Dodson Health Center Medical Director: Curtis Cary, MD
Clinical Competency and Quality Improvement Committee Chair: Jay Sizemore, MD
Chief Resident: Brooklynne Makaya MD
Bedside Teaching Faculty Lead: Mukta Panda, MD
Curriculum Faculty Lead: Maria Tudor, DO
Mentorship Faculty Lead: Howiada Salim, MD
Quality Faculty Lead: Taylor Wootton, MD
Remediation and Procedures Faculty Lead: Laura Youngblood, MD
Residency Program Coordinator and Department Manager: Ms. Deborah Fuller
Clerkship Coordinator & Internal Medicine Administrative Assistant: Ms. Joyce Poke
Administrative Assistant: Ms. Ashly Herron

The administrative offices of the Department of Medicine are located on the 2nd floor of the Whitehall Building, Suite 200.

The Departmental Office extension is 2998.

The departmental e-mail address is UTintmed@erlanger.org.

Office Hours:
Weekdays, Monday- Friday
8:00 AM- 5:00 PM
Summary of the Program Graduation Requirements

1. American Board of Internal Medicine (ABIM) requirements
   [www.abim.org/certification/policies/imss/im.aspx]
   36 months of Medicine training must include the following:
   a. 30 months on internal medicine rotations (general or subspecialty IM and ER)
   b. 24 months of direct patient responsibility (patient care months)
   c. 6 months minimum of direct patient responsibility during PGY1 (i.e. inpatient medicine, night medicine, critical care)
   d. Up to 3 non-IM electives (pathology, radiology, etc.)
   e. No more than 3 months of leave over 3 years (which includes vacations, CME)

   Months at UTCOM Chattanooga that meet the ABIM definition of the above:

   Direct Patient Care Months (need a total of 24 months and may include)
   - Ambulatory
   - Heme-Onc
   - Global Health
   - Inpatient Medicine
   - Infectious Disease
   - Nephrology
   - Critical Care
   - Emergency Medicine
   - Private Office
   - Cardiology
   - Night Medicine
   - Hospitalist
   - Gastroenterology
   - Pulmonary, Inpatient

   Internal Medicine/Primary Care Rotations that are not Direct Patient Care Months
   - Endocrinology
   - Pulmonary, Outpatient
   - Sleep Medicine
   - Sports Medicine
   - Geriatrics
   - Rheum
   - Psychiatry
   - Neurology
   - Palliative
   - Cardiology, Outpt
   - Dermatology
   - Gyn, outpatient

   Non-Internal Medicine Electives
   - Research
   - Radiology/IR
   - Pathology
   - Leadership
   - Surgical Critical Care

2. ACGME Internal Medicine Residency Review Committee (RRC) requirements
   [http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/140_internal_medicine_2017-07-01.pdf]
   a. At least 130 sessions of continuity clinics
   b. At least 1 month of ER
   c. At least 3 months of Critical Care and no more than 6
   d. At least 1/3 of residency experience outpatient and 1/3 inpatient

3. Successful progress through the ACGME/ABIM Milestones
   [www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/InternalMedicineMilestones.pdf]
   as determined by the Clinical Competency and Quality Improvement Committee

4. Demonstration of competence in the core competencies on monthly & semi-annual evals
   a. Unsatisfactory/Marginal performance on evaluations may require repeating a rotation

5. Mini-Clinical Evaluation Exercises (CEXs) completion-
   a. PGY1- 4 must be completed by the first 6 months
   b. PGY2 and PGY3- 2 required each year
6. Completion of the resident **scholarly activity** requirement
   a. 21 points total and encourage obtaining at least 3 points each year.
       PGY3s must obtain points during the PGY3 year
   b. All PGY2s and PGY3s must be involved in a Quality Improvement Project

7. Education for Life requirement Statement submitted at final Semi-annual evaluation

8. Completion of ABIM and Departmental **procedure requirements**
   Central venous line: 5 (must be signed off for PGY2 promotion)
   Arterial stick or line 5
   Pap Smear: 5
   Intubation: 5 (may not perform with attending supervision)
   Thoracentesis: 3
   Arthrocentesis: 3
   Skin/Punch biopsy: 3
   Lumbar puncture: 3
   Paracentesis: 3
   Peripheral IV: 3

9. Every resident must evaluate each rotation, each attending, peers, and the program

10. A passing score on USMLE Step 3 is required before promotion to PGY3, per UT policy.
    Residents must be registered to take the exam by February 28 of the PGY-2 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 2nd year may be grounds for non-reappointment or dismissal from the program.

11. Residents must maintain **active ACLS** certification all 3 years

12. Attendance at scheduled conferences is expected. Failure to meet a **minimum of 75%**
    attendance may result in referral to clinical competency committee

13. Please contact attending and Department (Program Coordinator, Program Director, or Chief
    Resident) of any absence from rotation (sick day, personal day, etc)

14. All schedule changes/requests must go through the chief resident

15. Completion of program assignments (i.e., Scientific American Medicine)

16. Handover Evaluation is required each year

17. Timely Medical Record Completion (dictations within 24 hours and signatures within 7 days) and
    Duty Hour Compliance and Completion (weekly)

18. Adhere to UT Policies Regarding Professionalism, Dress Code, and Patient Privacy
    (see Appendix) and Sign Department Professionalism Contract
Resident Clinical Experience and Educational Work Hours (Duty Hours)

ACGME Common Program Requirements for Clinical Experience and Educational Work Hours, effective July 1, 2017:
1. Resident 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 hrs/shift, plus may spend up to an additional 4 hrs 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 Duty Hours Module on a daily basis. 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.

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”
   a. Our “Long admit” team that admits 8am-8pm should be logged as “Regular Duty” NOT “Call” which is defined by the ACGME as a 24 hours shift
3. Types of duty hours in New Innovation
   a. Regular Duty Hours- The majority of shifts will be entered as Regular duty
   b. Call- This is defined as 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 from your regular overnight call hours.
   d. Night Float
   e. Moonlighting Duty- must be logged in New Innovations
   f. Vacation/Leave- This is for Vacation, Personal Days, or Sick days.

   Regular Off days do not need to be logged

Two new duty types have been created in New Innovations to accommodate the 2017 ACGME work hours requirements:

1. Exceptional Circumstances (with attribute 'OK after 28 hours): 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.
2. 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.

To maintain duty hour compliance, please sign out pending duties to night float.
Supervision
All Residents and Interns will be supervised by an attending physician. The level of supervision is dependent upon the rotation and there is graduated authority and responsibility with advancement in training program.

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

Intern Supervision
When an intern is working a senior or attending must always be immediately available
- **Indirect supervision with direct supervision immediately available**
  - Perform H&P
  - Order routine Medications
  - Order diagnostic tests
- **Direct Supervision**
  - Decision to call a consult (*senior or attending*)
  - Change code status (*senior or attending*)
  - Decision to discharge a patient (*attending*)
  - Perform procedures (*senior or attending*)

Senior Supervision
When you become a senior more responsibility will be
- **Oversight**
  - Perform H&P
  - Order medications
  - Order diagnostic tests
  - Evaluate unstable patients
- **Indirect**
  - Decision to call non-urgent consults
  - Change code status
  - Perform procedures signed off on
- **Direct**
  - Performance of procedures not signed off on
  - Intubation

Ambulatory Supervision
Interns must see all patients with an attending the first 6 months of residency
After 6 months the attending will decide which patients he/she must physically see
Guidelines for Calling an Attending

Anytime a resident considers calling an attending, please do so. We always welcome discussion of any question or issue. Each attending physician bears medical, legal, and ethical responsibility for the quality of care received by each patient admitted to him or her and managed by a house staff team. Resident teams should understand clearly the need to inform their attending of the clinical status of patients sufficiently to allow appropriate attending physician oversight. Each attending physician must give appropriate oversight while allowing residents progressive opportunities for decision-making and responsibility.

Please always contact an attending during the following circumstances:

1. Any major change in a patient’s condition; including, but not limited to transfer to Intensive Care, Code Blue, Rapid Response, Need for emergent invasive procedure

2. If there is a suspicion the patient is hospitalized as a result of criminal activity (i.e., evidence of trauma/abuse/rape)

3. Patients must be discussed with an attending prior to a patient being discharged (Pts may not be discharged without approval of the attending)

4. Interpersonal conflict with a patient or family member

5. Prior to any invasive procedure (unless emergent)

6. Patient leaving Against Medical Advice (AMA) or Elopes (leaves without notifying staff)

7. Patient death

8. Medical Error
Evaluation
A. House Staff will be evaluated by attending physicians and peers at mid-month and end of month in Medical Knowledge, Patient Care, Professionalism, System-Based Practice, Problem Based Learning, Interpersonal Communication Skills
B. House staff will also have the opportunity to evaluate faculty and peers.
C. House staff will evaluate the program by both the UT GME survey and the ACGME survey annually.
D. The Clinical Competency and Quality Improvement Committee (CCQIC) meets 3-4 times during the year to review resident evaluations and, as a committee makes recommendations on feedback and promotion.
E. The CCQIC and Program Director review resident progress through the Milestones
F. Semi-Annual Evaluation
   i. The Program Director (PD) or Associate Program Director (APD) meets with each resident at least twice per year to review his/her individual evaluations and gives feedback as to how the resident is progressing through the residency.
   ii. Peer evaluations are not available to be reviewed by the resident but will be reviewed with the resident at the semiannual evaluation with the PD/APD
G. The Program Director ultimately is responsible for deciding if a resident has met the requirements for promotion to the next level and for graduation
H. Residents must achieve competence in each content area required by the ABIM and ACGME

In-Training Examination
The In-Training Examination is an exam administered to all Internal Medicine residents across the country each fall. All residents receive 2 scores, a total percentage correct and a percentile rank comparing the individual’s score to other PGY1s, 2s, and 3s across the country. The In-Training Exam is not used for promotion. All residents receive a score breakdown and list of objectives incorrectly answered. Residents should use the feedback to focus areas of study. Residents who score below the 30th percentile nationally will be placed on an individualized reading plan. Those below the 30th percentile will also not be eligible to moonlight.

Traditionally those who score in lower percentiles have been at risk for failing the ABIM board exam. Our goal with the individualized reading plan is to help residents achieve success on their board exam.
Independent Reading / Learning
We are all physician and adult learners who have made a commitment to Life-long learning. Residents are expected to read assigned readings in Scientific America and also read related to your patients.
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

Internal Medicine Department Leave Policy

1. **General Guidelines**
   a. Per UT Policy 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 absence from 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) vacation leave per academic year
      ii. Five personal days total over the 3 year training period
      iii. Up to one week of Continuing Medical Education each academic year if attending a regional or national conference
      iv. One week of Continuing Medical Education each academic year
   e. **Reminder for PGY3s**: Your appointment ends June 30th, if you plan to leave prior to June 30th (after graduation) please make sure you have sufficient vacation time.

2. **Unexpected Absences**
   a. If an emergency situation arises causing you to miss a workday, you should notify your attending and attempt to arrange coverage, if needed. You must also notify the chief resident, program director, and Dept. of Medicine Office at ext. 2998. If at all possible, please do not miss a call day because this disrupts patient care and resident assignments. If you are not able to arrange coverage, you must notify the chief resident (or program director) and your attending. **If you are absent from your residency duties for 3 or more consecutive days, you must provide a statement from your physician that you are medically able to return to duty**. Sick days may be made up on weekend within the same calendar month.

3. **Vacation Leave**
   a. **Must be scheduled and all signatures obtained on the leave approval form by the first day of the month prior to the month of the requested vacation** (Example- leave requested Sept 30th, leave request form must be submitted by August 1st)
   b. Residents **MAY NOT** schedule vacations during Inpatient Medicine, Night Float, Critical Care, Cardiology, or Emergency Medicine. All vacation requested for the 1st week of a rotation month must have rotation Attending’s approval signature obtained by therresident before therequest will be considered.
   c. Unused vacation leave cannot be utilized in a subsequent academic year
   d. No more than 1 resident on the same rotation off unless special approval granted
   e. Granted on a first-come, first-approved policy
   f. No leave for travel outside of the US will be approved during the last 2 months of a currently valid non-resident visa or passport until renewal has been obtained. The resident must also adhere to 1(b) above.
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.

h. 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. Resumption of residency will require reapplication for admission and is not guaranteed.

4. **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

4. **Leave for Presentations at State and National Meetings**
   a. Approval contingent on the ability to provide adequate patient care coverage as well as academic considerations.
   b. Arrangements 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.
   c. If approved, the Department of Medicine will provide residents with reimbursement according to departmental guidelines for presentations at state or national meetings.
   d. No more than one regional or national meeting will be funded by the Department 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.
   e. 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.

5. **Leave for Interview Dates**
   a. 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.
   b. As soon as an invitation for an interview is received, the resident must contact the chief resident and supervising attending.
   c. Residents must have sufficient vacation and/or personal days available for the expected dates of leave – no additional time away is granted for interviews; thus, residents anticipating the need for fellowship and/or job interviews should schedule their other leave periods accordingly.
   d. A signed leave form must be returned to the Program Coordinator prior to the absence
d. The resident is responsible for arranging coverage for patient care during his/her absence.

6. **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.

7. **Personal Days**
   a. Five personal days will be granted over the 3 years.
   b. Personal Days cannot be taken on a clinic day.
   c. One week’s notice is expected. If an emergency occurs which does not allow a 1-week notice, call the chief resident, Program Coordinator or PD to discuss the situation.
   d. 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.

8. **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.
9. **Leave of Absence, Family Medical Leave, Bereavement Leave**
   Please refer to GME Leave Policy

10. **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.
Reimbursement for Professional Educational Development and Educational 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 the 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 are 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

4) Hard copy medical-related books

5) Board Reviews (hard copy, CD-ROM, online, etc.)

6) USMLE Step 3 Prep Course or materials

7) Membership fee for specialty organizations

8) USMLE Step 3 registration fee*

9) Smart phone

10) iPad or similar tablet

11) Laptop computer

12) Small medical equipment such as a stethoscope, surgical loupes, or neural reflex hammer

Non-approved expenses (may include but are not limited to the following):

1) Certification board exam fees

2) Medical license fees

3) Printers, including palmtops

4) Digital cameras
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 you must submit the original receipt with breakdown of taxes/fees and the receipt must denote Coach Fare.
- To be reimbursed for hotel you must submit the original receipt from the hotel with breakdown 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.

For further details, refer to the UT GME Travel, Professional Development Expenses, and Reimbursement Policy in http://www.comchattanooga.uthsc.edu/docs/UT_GME_Institutional_Policies_20172018_in_pdf_final.pdf
Inpatient Medicine Teams and the Night Medicine

1. All three Inpatient Medicine Teams are available for daytime admissions.
   i. All Teams are open for new admissions until 3:00 pm (although the non-admit teams typically on accept new patients from night medicine at the morning handover)
   ii. The Long-Admit team remains in-house until 8:00pm

2. The Night Medicine Team covers all patients from 8:00pm-8:00am

3. Off days for Inpatient Medicine
   a. Seniors and Interns alternate pre-admit days off (total of 4 off days during month) and no off days during last day of month or first 3 days of month (Example below)

If 1st Long Admit Day falls on Monday

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Team A Intern Off C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Senior Off C</td>
<td>A- Long Admit</td>
<td>B</td>
</tr>
<tr>
<td>Team A Intern Off C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Senior Off C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Intern Off C</td>
</tr>
</tbody>
</table>

If 1st Long Admit Day falls on Tuesday

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Senior Off C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Intern Off C</td>
</tr>
<tr>
<td>B</td>
<td>Team A Senior Off C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Intern Off C</td>
<td>A- Long Admit</td>
<td>B</td>
</tr>
<tr>
<td>Team A Senior Off C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Intern Off C</td>
<td>A- Long Admit</td>
<td>B</td>
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</tr>
</tbody>
</table>

If 1st Long Admit Day falls on Wednesday

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Senior Off C</td>
<td>A- Long Admit</td>
<td>B</td>
</tr>
<tr>
<td>Team A Intern Off C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Senior Off C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Intern Off C</td>
</tr>
<tr>
<td>B</td>
<td>Team A Senior Off C</td>
<td>A- Long Admit</td>
<td>B</td>
<td>Team A Intern Off C</td>
<td>A- Long Admit</td>
<td></td>
</tr>
</tbody>
</table>

5. A backup/jeopardy resident is assigned each day and may be pulled for inpatient service in the event of unexpected illness, emergency, other. The backup/jeopardy resident is also available for phone calls from interns when the senior is off. The backup/jeopardy resident is required to have his/her pager on at all times.
6. Morning handover occurs in WW7 at 8:00 am and 8 pm daily. All teams should be present for morning handover. Bedside rounds should occur after the handover.

7. Night float admissions will first fill the post-call team to the team limits per the team attending, then the other teams will accept remaining patients.

8. During each 24 hour period, there will be a limit of 10 new patients to the Medicine team (8 if single intern or no intern team). No more than 5 admissions per intern in 24 hours.

9. The total team census for a single intern team cannot exceed 14 and for double interns 20.

10. Admissions accepted after 6:30 PM can be held for the night float intern after the resident assures that the patients are adequately stabilized by the Emergency Department staff and that timely workup has been initiated.

11. The Long-Admit senior resident is responsible for attending all in-hospital “codes” (Code Blue) and should be at the head of the bed to provide direction. The Cardiovascular Diseases Fellow and the Rapid Response Team will come to codes for supervision. 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.

12. Orders must be written only by the house staff caring for the patient on teaching services except for procedural orders, chemotherapy orders, or emergency situations. Verbal orders should be avoided when possible or must be signed within 24 hours.

13. 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.

14. A full SOAP note is expected on all follow-up patients. If the intern has written a full SOAP note, the senior resident may write a concise note, but the senior must document in the progress note any additions or changes from the intern assessment and plan.

15. Backup for Team Seniors: Residents should call for backup for any acute or routine question anytime needed. The situation should dictate who to call first. However, the following are suggestions for assistance:
   1. Resident In-house or Attending on Call
   2. Backup senior resident
   3. Program Leadership (PD, APD, Chief Resident, Attendings)
   4. Rapid Response Team

16. Changeover for all rotations for both interns and residents (except Night Medicine) will be Mondays. On Night medicine, the residents starting on Night Medicine will begin Sunday night.
**Admissions from the Medicine Clinic**

Any patients admitted from UMA will be admitted by the resident evaluating the patient in the clinic. The clinic resident or intern will be responsible for notifying the bed desk (778-8100) of the admission, providing verbal and written handover to the on-call team, and writing basic initial admitting/holding orders. The receiving team will complete the admission History & Physical and dictate the H&P for the inpatient record.

**Readmissions**

If a patient has been admitted in the past 30 days with a similar presenting problem, the patient should be readmitted to that same service (i.e., Family Medicine, Hospitalists, Inpatient Internal Medicine). 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 & Attending Teaching Rounds**

1. Pre-rounds/Work rounds are to be conducted by the resident, intern(s), and medical student(s) prior to attending rounds.
2. The senior is responsible for providing oversight of the interns on all patients on the census prior to attending rounds.
3. 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.
4. The timing of teaching rounds will occur at the discretion of the attending and team members.
5. Management issues may be discussed in conjunction with didactics.
6. 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. Interns and Residents are expected to have read up to date literature on their patients.

**Consultations**

1. **Consults should be called by the intern/resident**
2. 3rd year medical students should **not** call in consults, Jls may call consult only if senior resident is present with JI.
3. 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.
4. Interns should speak with their senior prior to calling a consult.
5. 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.
6. 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**

1. 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.
2. Only the **senior resident or attending** can talk to the transferring physician to accept a transfer.

3. **Allfloor transfers to 3000 Medicine 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 Medicine 3000 (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.

4. **Remember, all calls are recorded!!!!**

5. Ask all relevant historical and clinical information: demographics, pertinent medical history, exam findings/V&S/labs/diagnostic studies/imaging. Is patient stable for transfer to a regular bed?

6. Ask for documentation to be sent with the patient and images be pushed to PACS, if relevant

7. Ask the bed desk/EROC if they know the patient’s **room number**. Tell them the name of the attending who it is to be admitted under and to **page 8000** immediately on arrival for all remaining orders

8. 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.

9. As always, please call attending-on-call if you have any questions or are uncertain about something.
Academic Hospitalists Expectations of Inpatient teams

Patient care:
- Know your patients well
- Thorough physical exam daily
- Review MAR and IVF daily and make adjustment as needed (most common areas of errors)
- Explain the plan of care for the patient daily, update them about studies and answer all the questions they have. Don't give any information that you are unsure of, say you will discuss with the team and update during rounds
- Communicate with patients’ family and update daily, especially if a patient is unable to communicate for themselves and document in the chart
- Review consultants’ note and recommendations
- Review physical and speech therapist notes and recommendations
- Communicate with the nurse in charge of the patient re. plans and issues
- Everyday ask “What can I do today to get the patient one step closer to going home?” (Can I stop IVF, remove lines, advance diet, change medications IV to PO, mobilize patients, etc)
- Follow up on all pending studies after rounds and update the resident or attending if resident is off
- When texting about the patient, do not use pt names (HIPPA compliance). When TigerText becomes available only use secure messaging
- E-mail check outs to attending daily and forward to the new attending when there is change in attending

Rounds:
- Rounding times are flexible to make sure all patients are seen, but should not be later than 10:00 am
- All patients should be seen prior to attending round by interns and residents
- Resident should coordinate work rounds and prepare the team for attending rounds
- Residents are the team leaders and are responsible to have full knowledge of all patients
- All team members should be available during round even if it is not their patient with full attention
- No texting or phone calls that are not related to patient care
- ENJOY ROUNDS!

Notes and documentations
- Dictate full and complete H&Ps with differential diagnosis and plan on the same day and CC the supervising attending
  - Full H&P components- see Intern Handbook/ “How to Guide”
- Provide complete full presentation on initial day of visit and concise presentation in SOAP note format of follow ups
- Document an addendum if any change in the patient clinical status or plan of care based on study result, family discussion or consultant recommendation
- Dictation of H&P and discharge summary should be done within 24 hrs
- Interim discharge summary for transferred patients should be done immediately before the patient leaves the hospital
- At the end of each block each intern is responsible for dictate an off –service/interim summary on all patients admitted for more than 5 days
Resident responsibilities

- Prepare the team calendar for the month including off days and morning report team presentation in advance for the Attending and chief resident
- Residents are the team leaders and are responsible to have full knowledge of all the patients in the team
- Writing concise note on the intern’s note and if any update.
- Rounding on and writing a full note on 4th year medical students
- Should be proactive in teaching medical students and interns
- Keep a log of morbidities and mortalities during the month
- Review the case presentation of the team with the intern and attending in advance
- Prepare M&M after discussing with the attending

Education

- Residents and interns are expected to read up to date literature on their patients
- Apply the literature in patient care
- Present assigned topics on time
- Share one teaching point about your patient with the team during rounds to have interactive teaching rounds
- Your patient is your teacher!! Enjoy the resources you have available!

Professionalism

Residents/interns are expected to:

- Demonstrate respect, compassion and integrity
- Adhere to ethical principles
- Demonstrate sensitivity and responsiveness to patients’ culture, age, gender and disabilities
- Professional attitude is expected all the time dealing with patient, patient’s family, colleague and ancillary staff
- Any personal or professional disagreement should be resolved in a diplomatic and professional manner

If you consider calling the attending...... CALL!

1. Do not hesitate to call your attending
2. While the resident is the team leader, the attending is ultimately medically and legally responsible for the patient
3. Notify the attending of any major change in the patient’s condition/decompensation, AMA/elopement, family/pt conflict with care team and/or death
Handover / Transitions of Care

Studies have shown that lapses in care can occur if a physician is not fully aware of a patient’s clinical situation; thus careful handovers of care are essential. See template below

1. Always use the standard template for Inpatient team handovers
2. The ICU to floor transfers should be in the I-PASS model and this will be incorporated into EPIC in the future for all handovers
3. Update the information daily
4. Handover must be written/electronic and verbal
   a. Electronic handover must be via secure means only. Store data only on encrypted/protected USB (ex.IRONKEY or APRICORN USB) and use Erlanger e-mail accounts only (NO PERSONAL EMAIL ACCOUNTS)
5. Seniors should review intern handovers
   i. Always review the first week when working with a new intern and directly supervised the first few handover sessions to ensure the important information is conveyed accurately and concisely
6. Provide the receiving intern with two copies of your completed template for sign-out - one copy for them and one copy for their supervising resident. Provide verbal handover in IPASS format.
7. Provide your contact information, as well as contact information for your resident and attending on the header of the sign-out. The cross-covering team may need to reach someone from your team.
8. Think carefully about tasks that you are handing over to the receiving team and be specific. If you want a lab value to be checked, indicate what time you ordered it to be drawn and what action should follow Tasks should follow “if, then” format. Example-Please follow-up 8pm H&H. If Hgb<7, then transfuse 1 Unit PRBC
9. Each morning at 8:00am handover, the night float intern must discuss with the inpatient teams any changes in the status of their patients as well as any new clinical problems which arose overnight
10. All handovers completed by 4th year medical students/J1s must be supervised by senior
11. All residents changing services are expected to verbally handover to oncoming resident

Off Service Notes/Monthly Patient Handover

At the end of each block, the intern is responsible for writing a detailed off-service note on all patients. If a patient has been admitted for more than 5 days, has been admitted to the ICU at any point during their stay, or has had any major procedure and/or complication a transitional discharge summary should be dictated. A transitional discharge summary is #64 on the dictation line. Both written and verbal handover should occur with each change of service.
Fatigue Mitigation and Management

- All residents receive formal training and education in fatigue or sleep deprivation as part of GME Intern orientation. Additionally, the GME office provides annual training in fatigue and sleep deprivation recognition and management.
- Call rooms are provided so residents may sleep in the call rooms.
- For those residents too fatigued to safely drive home, especially after a 24 hour shift, may call a taxi to drive them home and may submit the receipt to the Department of Medicine office for reimbursement from the GME office.
- Residents who perceive that they are manifesting excess fatigue and/or stress have the professional responsibility to immediately notify the attending clinician, the Chief Resident, and the Program Director without fear of reprisal.
- Residents recognizing Resident fatigue and/or stress in Resident colleagues should report their observations and concerns immediately to the attending physician, the Chief Resident, and/or the Program Director.
**Patient Safety and Quality and Incident Reporting**

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.

You will receive training during didactic sessions as a part of Noon conference, Health Care Principles in Practice, and your QI ambulatory mini-block in patient safety and quality.

**Practice Data**

Erlanger supplies practice data for the Inpatient medicine teams. EPIC will soon supply data to the clinic. All seniors will be expected to review their data during a QI block and come up with a QI project.

**Photos**

Do not take photos of any health care protected information (chart, notes, etc)

When taking a photo for educational purposes (conference, abstract, etc) written consent must first be provided by the patient.

Educational photos should also be taken by medical photographer and not on personal device.
Medical Record Completion Policy

Inpatient Rotations
1. All H&Ps need to be dictated the day of admission
2. Discharge Summaries should be dictated the same day and should not exceed 24 hours
3. Discharge summaries need to be completed on all patients admitted to the hospital, including those admitted for 23-hour observation
4. All records need to be signed in HPF in a timely manner
5. **Any records exceeding 7 days are delinquent**
6. Records exceeding 14 days will require action by the Department

Continuity Clinic
1. Notes in EMR should be completed prior to leaving clinic
2. EMR desktops need to be checked **daily**

Residents are encouraged to complete records on a daily basis to avoid ANY delinquent charts.

See Resident Handbook for H&P and DC summary templates

Discharge Summaries
All patients discharged to nursing homes or other medical facilities must have a completed discharge summary to accompany the patient. This summary can be dictated on a STAT basis for immediate transcription. If somehow the transcription has not come up prior to the time of patient transport, please instruct the nurse to send a copy of the handwritten discharge instructions and discharge medications, as well as your most recent progress note, to accompany your patient until the transcription is available. Advanced directives completed in the hospital MUST be attached to this summary.

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.
Scholarly Activity Requirement

Clinical research is a key mission of the Department of Internal Medicine. Faculty investigators at College of Medicine are known for results with high impact on improving health outcomes.

The UTC Internal Medicine Residency Program promotes and nurtures resident research and productivity to:

- 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 academic medicine

All Internal Medicine residents are required to carry out scholarly activities and obtain at least 21 points during the 3-year for graduation and some scholarly activity must be completed during your 3rd year of the residency program. There are diverse opportunities, including case reports, literature reviews, teaching conferences, quality improvement, and clinical research projects. Residents are strongly encouraged to directly become involved in clinical research, including patient-oriented research.

Research Goals and Objectives

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.

Research Studies

Residents can choose one of the following study designs

Prospective Clinical Studies: 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.

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 later 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 later part of the first year or early part of the second year of residency.

**Scholarly Points for Research**
The process of developing, conducting, analyzing, and publishing a study is long and it is possible that a resident may not be able to complete all these steps in a timely fashion; for example, often acceptance at a peer-reviewed medical journal takes several months. While the ultimate goal of the research is to have it published, each stage of the process is given some points to have residents obtain credit towards their yearly scholarly goal.

**Justification for Scholarly Points**
The scholarly points are not a reflection of time devoted towards a project but a reflection of completion of certain stages of a research project and relative importance of those stages within a research project. The ultimate goal of a research project is publication in a peer-reviewed journal; without a publication, a research 'never' happened for the outside world. Hence, maximum points are given for manuscript publication. Preparation and acceptance of the proposal by SRC highlight the fact that the study question and design are reasonable. Acceptance by IRB confirms that the patient safety and data confidentiality aspects of the study are adequate. The process of data collection and data summary exposes a resident to the nuances of in-the-field issues with data collection and subsequent analyses. Therefore, all these activities are given a total of 14 points to recognize the learning that a resident goes through. Below is the list of points for research activity. We have recently added some community service activities that count towards this point system, we recognize this is not a true scholarly activity but want to promote, encourage, and reward community service activities.

**Scholarly Activity Requirement 2017-2018**

<table>
<thead>
<tr>
<th>QI/Research Project</th>
<th>max 35 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation and SRC acceptance of proposal</td>
<td>3 points</td>
</tr>
<tr>
<td>Acceptance of IRB</td>
<td>3 points</td>
</tr>
<tr>
<td>Data collection and data summary (with faculty review)</td>
<td>3 points</td>
</tr>
<tr>
<td>Poster presentation of research/QI</td>
<td>5 points</td>
</tr>
</tbody>
</table>

*Manuscript acceptance in PubMed listed journal*

- **First author**
  - 21 points
- **Second Author**
  - 15 points
- **Third Author**
  - 10 points
- **All Authors after Third Author**
  - 5 points
Manuscript acceptance in non-PubMed listed journal

First author 15 points
Second Author 10 points
All Authors after Second Author 5 points

Other Scholarly Activity Points
Case Report published in a PubMed listed journal 10 points
Case Report published in a non-PubMed journal 7 points
Grand Rounds 7 points

Grand Rounds presentation should be mentored by a faculty

Workshop Presentation at regional/national meeting 7 points

Mentored by a faculty
Creation of Evidence Based Order set approved by hospital 6 points
Book Review Published in a peer-review journal 6 points
Letter to the Editor Published in a peer-review journal 6 points
Commentaries Published in a peer-review journal 6 points
Case Report Poster presented at regional/national meetings 5 points

TNACP Jeopardy (2 points for questions/ 1 point for running/1 point for winning) 3 points
Invited Lectures (including Lunch and Learn) 3 points

These lectures should be scheduled after identification and consultation with a faculty mentor who will guide the preparation of the presentation. Points are only for new lectures. If the same lecture is repeated, only one point is given for each repetition. Points will only be granted after written evaluation from the faculty has been received.

Quality Improvement Committee (one year of regular meetings) 3 points
Participation in Health Fair (with written reflection) 2 points

The resident is responsible for providing to the program coordinator, PD/APD a copy of all abstracts, manuscripts, conference handouts, etc for which the resident desires credit for the scholarly activity requirement.

Before a research project is started please identify a mentor and sign a mentor/mentee agreement. The mentor must approve the project before it is submitted to conferences, journals, etc.

Please keep the Google Drive spreadsheet updated regarding ongoing projects
**Conference**
1. Please see monthly conference schedule for required conferences, which includes: morning report, rapid fire, noon conference, journal club, M&M, grand rounds, and Health Care Principles in Practice
2. Please be respectful of the presenter and be on time
3. Residents are expected to attend all conferences when on rotations during the day in the hospital unless an unstable patient requires attention.
4. Residents on night medicine, off-days, vacation, and off-site rotations are not expected to be present, but all others should be in attendance.
5. Grand Rounds and Health Care Principles and Practice are recorded to permit residents to view at later times.
6. Residents are responsible for the accuracy of sign-in log.
7. Signing in for days not attended or for other residents is unethical and unprofessional.

**Resident Report “Morning Report” format:**
- Case presentation (Not in lecture-style).
- Interns may help with the case presentation, but morning report is primarily the SENIOR’S responsibility. NO M3 MEDICAL STUDENTS
- Powerpoint is not required but encouraged for illustrations, algorithms etc.
- Present the history first (HPI, PMH, SH, FH social) then open for questions. (Don’t start the case by, for example, Pt presented with Fever, nausea, and vomiting, what is the DDx?)
- Differential Diagnosis (use a systematic approach), you should have at least 5 DDx items. It is the presenter’s responsibility to ensure the DDx list is sufficient.
- 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.
- Diagnosis
- Management
- Discussion. Explicitly state 2 or 3 teaching/take home points.
- Discuss the case with the faculty member at least 48hrs before the presentation.
- The general format can be summarized by 10-4-3-2-1, meaning no more than 10 slides, NO MORE than 4 text slides, at least 3 learning objectives, at least 2 reference sources, and 1 faculty review.

It is your choice to focus on one aspect vs. another in your presentation (e.g. more on diagnostics vs. management vs. Pathophysiological discussion)

**Rapid Fire**
Preparation:
- Each inpatient team, including consult teams, should come prepared to share the details of 1-2 cases. No powerpoint or teaching presentation required.
Format:

- Moderator will ask each team for a one-line teaser about their case and then write these on the white board or type into powerpoint to project on the screen (ie. 27 y/o with cough; 52 y/o with fever). The resident should let the moderator know if the case is particularly interesting. This can be noted with a star.
- The moderator then asks a resident in the audience to choose a case to discuss. This person becomes the discussant.
- The resident whose case is chosen (the presenter) then presents the case in usual morning report fashion, stopping after HPI for questions and pausing after the exam for a differential.
- The moderator asks the discussant for a differential and then opens the discussion to the audience.
- The resident presenter then shares laboratory and imaging results, as requested by the discussant and the audience.
- After a final differential is made, the presenter reveals the diagnosis. It is acceptable for a case without a final diagnosis to be presented. This is actually a helpful way for a team to get new thoughts on a challenging case.
- The above process is repeated in as many cases as possible until the time allotted for the conference has ended.

Morbidity and Mortality Conference format:

- Focus on 1 case
- Use Root Cause Analysis (RCA)Format (see PowerPoint sample on Sharepoint Drive)
- Include confidentially statement “Confidential and Privileged Quality Peer Review Protected Material Created Pursuant to the TN Patient Safety &Quality Improvement Act of 2011 and the Health Care Quality Improvement Act” if any written info provide (PowerPoint or other)
- Explain why case being presented
- Give background on patient
- Review Error Analysis- this should be a back and forth discussion with the audience and include the RCA review
- Provide 2-3 evidence based points on best practice that you learned from case
- Provide proposed actions (generated from group discussion) to prevent future similar problems
Moonlighting

1. PGY2/3 residents desiring to moonlight must notify and have written permission from the Program Director prior to moonlighting.
2. Those below the 30th percentile on the ITE will not be permitted to moonlight.
3. The request should include the time, place, and hours of moonlighting, and should be submitted prior to the scheduled activity.
4. 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.
5. Moonlighting schedules must be sent by e-mail to Ms. Deborah Fuller at the beginning of each month including dates, location, and duty hours.
6. No moonlighting is allowed during Inpatient Medicine or Critical Care rotations.
7. Moonlighting hours must be logged into New Innovations and total duty hours (residency shifts + moonlighting) may NOT exceed 80 hours per week.
8. Moonlighting schedules should not interfere with your regular duties. Residents should not leave their rotation site before 5 PM or before their duties are completed in order to begin a moonlighting shift.
9. Moonlighting must not interfere with meeting the requirement of having at least 8 hours between work assignments.
10. 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.

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 Student Responsibilities

M3 Medical Students:
1. M3s are supervised by the team intern
2. Students are to be assigned 1-2 new patients per call
3. Medical students should be carrying a minimum of 2 patients and up to a max of 5
4. They are to perform comprehensive H&Ps with a complete A&P for each problem.
5. M3s are expected to write daily progress notes
6. Students notes do not count for billing purposes, so full notes must still be completed by interns (on M3) and seniors (on M4s)
7. They are expected to pre-round on their patients and present during work and attending rounds
8. Please review all physical examination findings with the students.
9. Review and practice oral presentations with the student their 1st few days prior to rounds
10. Please have the students write orders on their patients whenever possible and co-sign
11. Students should have at least 2 SOAP notes evaluated and corrected by the resident
12. During the course of the Clerkship, students are to be 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.
13. H&Ps must be completed within 24 hours and turned into the resident. The resident needs to review them as soon as possible (within 24 hours) and return them corrected to the medical student. The medical students will turn in their corrected H&Ps to the Clerkship Director.
14. Students may not dictate.
15. Feedback should be provided regularly (daily) and they are expected to complete mid-month evaluations from the attending and resident.
16. The Medicine shelf exam is taken the last Friday of the clerkship.
17. Students are expected to abide by the 80 work week.
18. Days off parallel those of your intern.
19. Days on call: students are excused at 8:00 PM.
20. If a concern arises regarding student performance or professionalism, this should be brought to the attention of the Clerkship Director immediately.

JUNIOR INTERNS (JI)
1. JI’s function as interns - directly under the supervision of the senior resident (not interns)
2. Orders should be written by the JI on all of his/her patients. These must be co-signed by the resident before the nursing staff can take them off. It is the JI’s responsibility to make sure that orders are not taken off until they are co-signed.
3. JI’s should admit 1-3 patients per call and should follow up to 5 patients at a time.
4. JI’s may not dictate
5. Duty hour rules apply
6. Feedback should be timely and include a written Mid-Month evaluation
7. Concerns about professionalism, performance, etc., should be brought to the attention of the attending and Clerkship Director as soon as possible
Patient Assignments

Continuity Clinic
During ambulatory assignments, patient visits for residents should average:
- PGY 1: 4
- PGY 2: 6
- PGY 3: 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- 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.
- If the team has admitted the maximum allowable patients for their team (8 or 10 depending on whether single or dual intern team), the “on-call” team cannot admit additional patients.

Consult Services
The numbers of admissions are not specified and the supervising attending will monitor
**Autopsies**
Residents should attempt to obtain autopsies for all unexpected deaths and may attend autopsies performed on their patients. When requesting an autopsy, always discuss with an attending first and 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 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 M&M. 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. Morbidity and Mortality 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 team attending of any team death immediately during daytime hours (8am-8pm) or at morning handover 8am for any overnight deaths, 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. Delays can cause undue financial burden for patient families.
Away Rotations

There is 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 President before arrangements can be finalized with the external institution.
Procedures
The American Board of Internal Medicine requires knowledge competence in the following procedures. The ability to competently perform those identified by asterisks is also required.

1. Abdominal paracentesis
2. Advanced cardiac life support (ACLS) *
3. Arterial line placement
4. Arthrocentesis
5. Central venous line placement
6. Drawing venous and arterial blood *
7. Incision and drainage of an abscess
8. Lumbar puncture
9. Nasogastric intubation
10. Pap smear and endocervical culture *
11. Placing a peripheral venous line *
12. Pulmonary artery catheter placement
13. Thoracentesis

Knowledge competence includes knowing and understanding the following for each procedure: Indications, contraindications, recognition, and management of complications, pain management, sterile technique, specimen handling, interpretation of results, requirements of and knowledge to obtain informed consent.

Procedure Requirement 2017-2018

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Required for graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central venous line**</td>
<td>5</td>
</tr>
<tr>
<td>-Subclavian</td>
<td></td>
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<tr>
<td>-Internal Jugular</td>
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<tr>
<td>-Femoral</td>
<td></td>
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<tr>
<td>Arterial stick or line</td>
<td>5</td>
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<tr>
<td>Pap Smear</td>
<td>5</td>
</tr>
<tr>
<td>Intubation***</td>
<td>5</td>
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<tr>
<td>Thoracentesis</td>
<td>3</td>
</tr>
<tr>
<td>Arthrocentesis/Joint injection</td>
<td>3</td>
</tr>
<tr>
<td>Punch/Skin biopsy</td>
<td>3</td>
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<tr>
<td>Lumbar puncture</td>
<td>3</td>
</tr>
<tr>
<td>Paracentesis</td>
<td>3</td>
</tr>
<tr>
<td>Peripheral venous IV</td>
<td>3</td>
</tr>
</tbody>
</table>

**5 required to become PGY2
*** May not perform independently
Must have attending supervision for all intubations

Log procedures in New Innovations

If a resident desires to obtain performance competence in any of the procedures 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 completed a sufficient number to be deemed competent to perform the procedure independently.

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.
**Disagreements between Residents and Interns**

Any disagreement (personal or professional) between residents or ancillary staff should be resolved in a diplomatic and professional manner. Please do not voice your disagreements loudly in the presence of patients, patient families, or at nursing stations. If the disagreement cannot be resolved between individuals, it should be brought to the attention of the attending. If it cannot be resolved at this level, the Chief Resident, Associate Program Director, or Program Director should be notified.

**Education for Life**

A principal objective of the Internal Medicine Residency Program is to foster life-long habits of critical thinking and continuing education. The program requires that a written Educational Plan for a Life in Medicine be presented to the Program Director prior to the PGY3 exit interview. Such a plan should consider (but not be limited to) the following:

1. Keeping up with the medical literature
2. Employing the literature in patient care
3. The role of continuing medical education meetings
4. The role of specialty society meetings
5. Self-learning
6. Audiovisual material
7. Computerized material
8. Preparing for recertification exams

**Resident Selection**

All applications for the residency program are given deliberate consideration. All applicants should have passed Part I and II of the USMLE on their first attempt. The ERAS system should be used for PGY-1 applications. Excellence in communication, teamwork, and interpersonal relationships are required. The Department of Medicine follows University of Tennessee policies concerning international medical graduate applicants.
**Program Evaluation Committee (PEC)**

The PEC is responsible for the planning, developing, implementing, and evaluating educational activities of the program. They should review and make recommendations for revision of competency-based curriculum goals and objectives.

The PEC should address areas of non-compliance with ACGME standards and review the program annually using evaluations of faculty, residents, and others.

The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.

Members include the program director, associate program director, program coordinator, core clinical faculty and representatives from each PGY class. Resident representatives will be appointed by the program director.

If you have any suggestions for program improvement you are welcome to bring these issues up at the resident business meeting or contact your resident representative to address at the PEC meeting.

**2017-2018 Resident Representatives**
PGY3- Drs. Shah and rising chief
PGY2- Dr. Doyle-McClam

Members of the resident council will occasionally be invited to select PEC meetings at the discretion of the program director. These are members voted by peers.

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

I- Resident performance
   a. including outcome assessment of the educational effectiveness of inpatient and ambulatory teaching *(i.e., In-Training Exam results)*
II- Faculty development
III- Graduate performance
   a. 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
   b. 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
IV- Program Quality
   a. Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually
   b. 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
V- Monitor progress on the previous year’s action plan
   a. the ability to retain qualified residents by graduating at least 80% of its entering categorical residents averaged over the most recent three-year period
VI- The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in thesection, as well as delineate how they will be measured and monitored.

VII- The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes
   a. The department should share appropriate inpatient and outpatient faculty performance data with the program director.
   b. 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.

Program Evaluation

Each resident is also required to confidentially complete an overall program evaluation annually. One evaluation will be submitted by the GME office and one is submitted by the ACGME. An aggregated summary of these evaluations (without individual identifiers) is provided to the Program Director and is reviewed with residents and faculty annually.
Professionalism

Professionalism Letter of Agreement
UT College of Medicine Chattanooga
Internal Medicine Residency

The goals of the residency program are to provide residents with experience in the art and science of medicine in order to achieve excellence in the diagnosis, care, and treatment of patients. As a resident physician, I recognize that I am in a noble profession where humanistic qualities foster the formation of patient/physician relationships. These qualities include integrity, respect, compassion, professional responsibility, courtesy, sensitivity to patient needs for comfort and encouragement, and professional attitude and behavior towards colleagues.

The purpose of having a professionalism agreement for residents is to remind you of the high professionalism expectations of a physician. In addition, this reinforces that all residents are evaluated in the professionalism competency based on their behavior in and out of the hospital. Professionalism is a broad competency that affects your success in all ACGME competencies.

In signing this, I agree to adhere to the professionalism expectations as outlined below, and I understand the potential for consequences for unprofessional behavior. Consequences may include, but are not limited to the following:

- Adverse evaluations
- Receipt of a failing rotation evaluation
- Placement on academic remediation or academic probation
- Termination of residency training

Agreement adapted from Naval Medical Center San Diego IM professionalism contract
Professionalism Letter of Agreement

I will exercise good judgment, integrity, and behavior both inside and outside the workplace to include, but not limited to the following:

- I will accept primary responsibility for the delivery of care to all assigned inpatients and outpatients. I will accept responsibility for the complete hand-over of those patients when I am going off duty. This commitment to patients and the medical profession may at times go beyond my own self-interest.

- I will do more than just my job, including being available to offer assistance as needed to patients, their families, my colleagues, and the clinic and hospital staff.

- I will willingly accept guidance, feedback, and evaluation from those with more experience and use this information to improve my practice and my behavior. I will recognize that I am not perfect but will reflect on how I can improve.

- I will conduct myself ethically and professionally and keep my position as a physician in the care of patients and in relationships between myself and other members of the medical staff. I will avoid unduly familiar relationships in the workplace.

- I will develop and participate in a personal program of self-study and professional growth. In doing so, I recognize that my program has a defined academic schedule, and I will attend, at a minimum, 75% of all scheduled didactic sessions. During didactics, I will not text, surf the internet, or act in any manner that is disrespectful to those who are working to educate me.

- I will demonstrate intellectual honesty and professional integrity in both clinical practice and academic endeavors. I will not plagiarize presentations and will provide credit/acknowledgment when I adopt or use the work of another as part of a presentation or didactic lecture. I will not knowingly copy or duplicate the patient care documentation of another physician or provider nor represent it as my own. I will comply with all HIPAA regulations, and not access medical records of individuals for whom I am not providing healthcare.

- I will always relate the truth in caring for patients and with my colleagues.

Name: _______________________________________________

Signed: _______________________________________________  Date: __________
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