College of Medicine
Phoenix

University of Arizona College of Medicine-Phoenix Internal Medicine Residency Housestaff Manual

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I. INTRODUCTION

The University of Arizona College of Medicine-Phoenix Internal Medicine Residency Program is committed to preparing residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients.

Residency education must occur in the context of a learning and working environment that emphasizes:

- Excellence in the safety and quality of care rendered to patients by residents today
- Excellence in the safety and quality of care rendered to patients by today's residents in their future practice
- Excellence in professionalism through faculty modeling of the effacement of self-interest in a humanistic environment that supports the professional development of physicians o the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

Additionally, all physicians share responsibility for promoting patient safety and enhancing quality of patient care.

This manual complements the UA COM-P Graduate Medical Education House Staff Manual (which forms the basis of the housestaff contract) and the more generic Banner Employee Handbook to list the program specific policies essential to maintain a community of learning that meets accreditation standards. Additional information about our program, clinical sites, schedules, and the curriculum is available at www.uaphxim.com, New Innovations, and through monthly intern/resident orientation meetings.

AIM

The aim of the University of Arizona College of Medicine – Phoenix Internal Medicine Residency Program is to train the next generation of knowledgeable, compassionate and resilient physicians to provide high value care to our community in an area of clinical practice that they are passionate about, whether it is primary ambulatory care, hospital medicine, an internal medicine subspecialty or academic medicine. As a mid-sized university program in one of the largest cities in the country, we prepare graduates to create and implement reliable care practices that enhance quality and improve safety through their participation in an innovative curriculum and clinical experience at a quaternary referral hospital (Banner – University Medical Center Phoenix) and the Phoenix Veteran's Administration (VA). Additionally, our program prioritizes a commitment to excellence and the support of each resident's individual personal and professional goals with the desire that our graduates be role models of self-care and wellness, as they promote the well-being of the patients they serve.

II. RESIDENT PERFORMANCE AND EVALUATION:

THE ACGME GENERAL COMPETENCIES

The Internal Medicine residency programs require that its residents obtain competence in the six areas listed below to the level expected of an independent practitioner of internal medicine. The specific

knowledge, skills, behaviors, and attitudes required during individual rotations have been defined by the faculty in the rotational goals and objectives and they are the core of resident assessment. These are distributed in new innovations prior to the start of every rotation and also are found in the UA COM-P Curriculum Manual.

The six ACGME core competencies are the following:

1. Patient Care (PC) that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
2. Medical knowledge (MK) of established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
3. Practice-based learning and improvement (PBL&I) that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
4. Interpersonal and communication skills (IP/CS) that result in effective information exchange and collaboration with patients, their families, and other health professionals.
5. Professionalism (Prof), as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
6. System-based practice (SBP), as manifested by actions that demonstrate an awareness of and responsiveness to the large context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

INTERNAL MEDICINE ROLES AND RESPONSIBILITIES BY YEAR

The roles and responsibilities that pertain to all internal medicine residents in all clinical settings at B-UMCP and the Phoenix Veterans Affairs Health Care System are listed in **APPENDIX 1: INTERNAL MEDICINE ROLES AND RESPONSIBILITIES BY POST GRADUATE YEAR** (updated 8/30/16). These are used along with the ABIM milestones (APPENDIX 2: INTERNAL MEDICINE MILESTONES AND TIMELINE) and ACGME reporting milestones for resident assessment.

MULTISOURCE ASSESSMENT

It is important for physicians to receive feedback from multiple sources in order to improve their skills. Performance is assessed periodically by patients, peers, and clinical/support staff in a variety of settings. The results of these assessments will be reviewed by the clinical competency committee twice a year as part of a comprehensive assessment. Each of these individually is designed to provide residents with more formative feedback to help you grow and learn:

- Continuity clinic nursing and support staff assessment
- Continuity clinic patient evaluations
- B-UMCP Inpatient ward nursing and patient assessments when available.
- Quality of patient care assessment based on continuity clinic panel data and select inpatients will be included in your semi-annual assessments whenever available.
- Other Formative assessments (e.g., Discharge summary, Simulation center assessments, Direct observation/CEX)
- New Innovations rotation assessment by faculty

Faculty Responsibilities in resident assessment

1. Review the learning objectives for the rotation

2. Provide verbal formative feedback noting behaviors that are working well and those that could benefit from improvement as a result of their own direct observations. This must occur in a formal way at least once prior to the end of the rotation.

3. Provide written feedback using the assigned forms and scales in new innovation within 2 weeks of the end of the resident assignment.

4. Report significant progression or performance concerns immediately to the program director or designee

Resident Responsibility in their assessment

1. Review the learning objectives for the rotation

2. Meet with attending for verbal feedback before leaving the service to discuss suggestions for improvement and discussion of specific strengths.

3. Review the written evaluations in New Innovations within one month of the date that it is signed by the attending.

4. Develop improvement plans for any areas that are deemed areas for growth.

5. Complete a formal semi-annual self-assessment and review progress towards these goals with your Clinical Competency Advisor/or Program Director. See Section below on faculty coach and Clinical Competency Committee.

CLINICAL COMPETENCY COMMITTEE (CCC) and CLINICAL COMPETENCY/APD ADVISOR

The objective of the CCC is to assure that each resident is progressing appropriately and achieving the milestones and competencies as outlined by the ABIM, ACGME and our faculty and to review requests for moonlighting or away rotations.

The CCC meets regularly and is chaired by one of the Internal Medicine Associate Program Directors. Every resident's progress is reviewed semi-annually and as needed by the CCC. Each resident is assigned a Clinical Competency/APD advisor who is responsible for reviewing them over time. In addition, issues regarding individual residents may be referred through a variety of ways and include but are not limited to academic progress, professionalism issues, patient care concerns, or moral and ethical behavior. These concerns are discussed in a confidential manner and then discussed with the resident. In some instances, it may be necessary to have the resident attend the meeting in person in order to set common goals and objectives between the individual and the Program.

The APD advisor meets individually with their assigned residents twice a year and as needed to discuss specific feedback that has been evident from the CCC review.

The CCC may assign non-disciplinary action or disciplinary action as listed in detail in the UA COM-P GME Housestaff Manual. The full policy and list of non-disciplinary and disciplinary actions are listed in the UA COM-P Graduate Medical Education Programs Housestaff Manual.

The CCC advises the program director regarding resident progress including promotion, remediation and dismissal. The CCC may recommends non-disciplinary action or disciplinary action as listed in detail in

the UA COM-P GME Housestaff Manual. The full policy and list of non-disciplinary and disciplinary actions are listed in the UA COM-P GME Housestaff Manual.

ADVANCEMENT CRITERIA FOR INTERNAL MEDICINE

Individual resident overall competence, moral ethical behavior, and performance in the 6 competencies are assessed in an on-going basis and progress in meeting milestones is reported twice per year to the Accreditation Council for Graduate Medical Education (ACGME) in approximately December and June of each year and then to the American Board of Internal Medicine (ABIM) in June of each year.

The Clinical Competency Committee (CCC) utilizes a scale of 1 to 4 (with level 5 being exceptional qualities) as they monitor resident progress towards becoming a competent Internal Medicine physician. By the end of your PGY 1 year, residents are expected to be achieving mostly 2.5 to 3's in the 6 competencies, 3 – 3.5 by end of PGY 2 year and 3.5 – 4.0 by completion of residency.

As outlined in the Program Director Ratings of Clinical Competence table below from the ABIM website, in order to receive credit, 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 components of clinical competence 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.

Six ACGME/ABMS Individual Competencies*		
Components and Ratings	Residents/Fellows: Not Final Year of Training	Residents/Fellows: Final Year of Training
Satisfactory or Superior	Full credit	Full credit
Conditional on Improvement	Full credit	No credit; must achieve satisfactory rating before receiving credit †
Unsatisfactory	Full credit	No credit; must repeat year

Overall Clinical Competence: This rating represents the assessment of the resident/fellow's development of overall clinical competence during this year of training.		
Components and Ratings	Residents/Fellows: Not Final Year of Training	Residents/Fellows: Final Year of Training
Satisfactory or Superior	Full credit	Full credit
Conditional on Improvement	Full credit	No credit; must achieve satisfactory rating before receiving credit*
Unsatisfactory	No credit; must repeat year	No credit; must repeat year

ABIM Definitions for Ratings are as follows: **Superior**: Far exceeds reasonable expectations, **Satisfactory**: Always meets and occasionally exceeds reasonable expectations, **Conditional on Improvement**: Meets some expectations but occasionally falls short, **Unsatisfactory:** Consistently falls short of reasonable expectations.

THE ROLE OF THE FACULTY MENTOR:

A faculty mentor is any faculty member of approached by the resident for advice regarding specific interests. (e.g. cardiology faculty to help with goal of preparing for a career as a cardiologist), Faculty mentors are informal and available through the resident approaching a faculty member to ask specific questions. Residents should approach the program director or APD advisor if they need assistance in identifying an appropriate faculty mentor to address a specific need.

III. EVALUATING FACULTY ATTENDINGS AND THE PROGRAM

The program believes it is imperative to be evaluated for continuous improvement. This supports the well-being of its faculty and residents and is essential for responding to change and maintaining its strengths. Additionally, the programs is committed to providing a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff.

DETAILS OF FEEDBACK MECHANISMS:

Feedback about attendings is provided through various mechanisms (see below for details). The feedback is compiled semi-annually to assure anonymity of those providing feedback and is provided directly to the attending in the form of a letter, which includes additional faculty development resources. These summative reports are also reviewed by the program director and faculty supervisor (when applicable) to identify consistent concerns. Urgent concerns should be addressed through using the program issues of concern form or verbal/direct written report to the program director or other program leaders.

There are numerous mechanisms for providing feedback and report critical incidents about faculty, co-residents and the program. These include:

1. **Evaluations assigned in New Innovations:** Residents are "assigned" an evaluation of their attending and rotation through New Innovations. These must be completed within 2 weeks of the end of the rotation. Additional evaluations for other attendings and peers are also assigned. By receiving a large number of evaluations from numerous sources, everyone can improve. If residents receive an evaluation assignment from someone who they have not had sufficient time to give meaningful feedback, the option of "Not enough time (NET)" should be marked.

   Anonymous evaluations: Resident evaluation of their supervisors and the program are confidential and anonymous. The title of the rotation, date and name of evaluator are removed so that the attending, advisor, program coordinator and program director cannot see who completed the evaluation. Each anonymous evaluation contains a header describing the process to assure the residents feel that they can provide honest feedback to those in senior positions:

   "This evaluation is totally anonymous. That means that the subject and the program will never see the individual evaluations. Faculty will only receive information through a summative report without identifiers no more frequently than every 6 months. The evaluator's name, date and rotation information are completely and irreversibly removed from the evaluation so that they cannot even be seen by the program coordinator or program director. If you have a concern that needs to be addressed within the next 6 months, complete a PROGRAM ISSUE OF CONCERN form…"

The following evaluations are totally anonymous:

- Intern evaluation of faculty
- Intern evaluation of a resident
- Intern evaluation of a rotation
- Resident evaluation of faculty
- Resident evaluation of a rotation
- Peer evaluation

2. **Program issues of concern (PIC):** For "on the fly" feedback or concerns that might not be captured in the above described end of the rotation evaluations or resident assessments, the Program has created the web-based "Program Issues of Concern" form. This provides another forum for residents and faculty to provide timely feedback about the Program, a faculty member, or a colleague in a secure, anonymous fashion. This should be used whenever there is an incident of concern involving the program, faculty or residents that was unable to be resolved or addressed through professional discussion and needs more timely attention than the semi-annual review of the evaluations in New Innovations or the individual preferred an alternate mechanism.. Incidents involving patient safety should be filed with the institutional incident reporting mechanism.
   The form is located on the www.uaphxim.com website under "Program Resources" on the right at the top. Direct link is http://www.uaphxim.com/#!pic-form/v7yrf. The password is uaphxim. The PIC form can be submitted anonymously or has an optional field for the name of the individual submitting the concern for additional discusison or receiving follow up. Once a PIC is filed, it is forwarded to the Program Director to determine next steps.
3. **Internal Program Surveys:** The Program asks faculty and residents to complete surveys on at least an annual basis to evaluate key aspects and provide input on recent or proposed changes. These typically use survey monkey and are anonymous unless stated. Participation in such surveys is an important way to provide feedback. The results of these and other results are used to create the Program's annual summary and action plan.
4. **Annual GME Office Survey:** This is conducted by the GME office mid-year and followed by a discussion of the results in a resident-only forum. The results of the survey and forum are summarized by the GME office and forwarded to the program director to incorporate in the program evaluation process.
5. **Direct Verbal or Written Feedback to program leaders:** The Chief Residents, APDs, faculty, Program Director and Institutional Designated Institutional Officer are willing to hear your ideas, suggestions and concerns. They review concerns with the program director.
6. **Internal Medicine Housestaff Council:** The housestaff council consists of elected volunteer members of the program. Through monthly meetings and informal discussions with peers, they hear of issues, concerns or ideas that are appropriate for further action. The members interface with faculty and the program director to bring about change and further provide information.
7. **UA COMP Grievance Policy/Process:** In the event that there is a significant concern about the program director or an issue that the program has not satisfactorily addressed through the above mechanisms, the Designated Institutional Officer (DIO) should be notified via the Grievance Process outlined in the UA COM-P GME Housestaff Manual

PROGRAM EVALUATION COMMITTEE:

Annually, a committee is formed with the Program Director, APDs, Housestaff Council representatives, a member of the office of the UA COM-P Office of Assessment and Evaluation and other members designated as appropriate. The charge of this committee is to review the program and prepare an annual Program Improvement Plan (PIP). The PIP includes specific projects which are worked on over the

course of the academic year. The plan and outcomes are communicated to all of the faculty and residents and are included in our Annual Program Evaluation submitted to the ACGME.

IV. SUPERVISION-THE ROLE OF THE TEACHING ATTENDING

RESPONSIBILITIES OF TEACHING ATTENDINGS:

Attending on the Teaching Service is a privilege of those faculty who have devoted their time and energy to teaching and have greatly influenced the development of excellence in this program.

The following criteria have been developed to assure excellence amongst our clinical rotations:

- Teaching Attendings must maintain both the priorities of the education of the house officer and the provision of excellent patient care.
- Regular patient-based teaching is the responsibility of the teaching attending and must include direct interaction between resident and attending, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions.
- Teaching Attendings serve as role models for the house staff in being on-time and physically present in order to provide appropriate supervision as outlined in the supervision policy. They will also be aware of resident time limitations when teaching and conducting bedside rounds.
- Housestaff and Attending staff will treat one another with appropriate professional courtesy and will work in a cooperative fashion to facilitate excellence in patient care through the following communication expectations which supplement the details in the supervision policy:
    - Direct verbal communication regarding admission, diagnostic work-up, therapeutic management, and discharge plans of patients.
    - Written communication through meaningful, appropriate progress notes in the patient's record, which will be utilized to provide additional communication, but should not substitute for direct communication.
    - Actual order writing is the sole responsibility of the house staff and will be the direct result of communication between house staff and teaching attendings. At times, attendings may write orders to facilitate urgent patient care, minimize administrative tasks by residents, or to minimize resident fatigue. If that is done, verbal communication directly to the resident of the order is required.
    - Supervising attendings must co-sign all daily progress note, procedure notes, H&Ps and discharge summaries.
    - Attendings on the teaching service are required to provide useful and constructive feedback to residents as outlined in the section on Feedback. Significant concerns or problems identified by teaching attendings about resident global performance, notable

trends or concerns about the immediate ability to perform assigned responsibilities must be directed to the Internal Medicine Residency Program Director.

  - Additional specific information on documentation and supervision at individual institutions and environments is provided in the respective appendix by location.

- Teaching faculty are required to participate in faculty development to enhance their skills in the areas of teaching, assessment, scholarship, patient safety, quality improvement, clinical coaching and mentorship, and many other areas that impact the experience of our housestaff.

- The selection of teaching faculty occurs on an annual basis by the program director with review of data regarding adherence to the above expectations and resident evaluations. Problems that are recognized will be discussed with the teaching attending by their supervisor or the program director with further actions including additional faculty development or other remediation.

SUPERVISION POLICY

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

Each patient must have an identifiable and appropriately-credentialed and privileged attending physician who is responsible and accountable for the patient's care. Supervision of the various aspects of that care is exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow.

As per the ACGME, the Levels of Supervision in our program are listed and mapped to specific training activities in the table below. Where required supervision is listed, the range reflects both the initial level of supervision for new trainees and minimum level of supervision provided:

1. **Direct Supervision** – the supervising physician is physically present with the resident and patient.

2. **Indirect Supervision with Direct Supervision immediately available** – the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.

3. **Indirect Supervision with Direct Supervision available** – the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to provide Direct Supervision.

4. **Oversight** – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members via direct observation and the clinical competency committee.

Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.

Activity Specific Supervision Expectations:

Activity	Resident training level	Level of supervision (numbers correspond with definitions above)
History and Physical and New Consults	Intern	Direct (1) initially and then progress to indirect with direct immediately available (2)
	Resident	Indirect supervision with direct available (3)
Follow up on own patient	Intern	Indirect with direct immediately available (2)
	Resident	Indirect supervision with direct available (3)
Discharge	Intern	Direct (1) initially and then progress Indirect with direct immediately available (2)
	Resident	Indirect with direct immediately available (2)
Transfers-higher level of care	Intern	Direct (1)
	Resident	Indirect with direct immediately available (2) BUMCP and Indirect with direct available (3) VA
End of life/Goals of Care	Intern	Direct (1) initially and then progress to indirect with direct immediately available (2)
	Resident	Indirect supervision with direct available (3)
Code Status	Intern	Direct (1) initially and then progress to indirect with direct immediately available (2)
	Resident	Indirect supervision with direct available (3)
Procedures	Intern	Direct supervision
	Resident	Depends on discussion with the attending to consider the procedure, patient and demonstrated competence. No procedures can be done without direct supervision until at least 3 successfully completed procedures are documented in new innovations.
Cross cover on other teach patient	Intern	Indirect with direct immediately available (2)
	Resident	Indirect supervision with direct available (3)
Sign out	Intern	Direct (1) initially and then progress to indirect with direct immediately available (2)
	Resident	Indirect supervision with direct available (3)
Error Disclosure	Intern	Direct supervision
	Resident	Direct supervision
Completion of safety event reports	Intern	Indirect with direct immediately available (2)
	Resident	Indirect supervision with direct available (3)

Rotation Specific Supervision Expectations:

- **ICU Rotations:** Daytime rounds are conducted on a daily basis with the critical care attendings, resident teams, and the remainder of the multidisciplinary team. The attending is responsible for leading the rounds and providing direct supervision of the residents. Following rounds, residents are responsible for accurately and completely following the outlined plan of care under direct supervision or onsite indirect supervision. Procedures are completed with direct supervision at

BUMCP unless specifically stated by the attending for that patient. Level of supervision for procedures at the VA ICU depend on the patient, procedure and competence of the resident. All endotracheal intubations must be completed by a certified expert.

- **BUMP/VA Ward Rotations**: Daytime rounds are conducted on a daily basis with the Faculty attending providing direct or indirect supervision. Pre-rounding should occur prior to formal rounds with indirect supervision. In this setting the resident shall gather important data pertinent for the upcoming formal rounds. After rounds, the resident is expected to complete the plan of care outlined on rounds accurately and completely.

- **Night Float**: Residents on night float function under indirect supervision, both onsite and offsite. Nocturnists or intensivists are immediately available for direct supervision as needed. Residents on night float are largely charged with admissions and evaluating decompensating patients. They must contact follow communication expectations and contact the on-call attending. Any patient decompensation resulting in an upgrade/ transfer level of care, unstable vital signs, complex evaluation and management, or other significant changes MUST result in a call to an attending (in house intensivist, nocturnist or the on-call attending) for notification and discussion of the treatment plan.

- **Consult Rotations**: General guidelines and rotation descriptions exist for each consult service. These should be reviewed prior to the rotation. There is a clear expectation that the resident and supervising consultant discuss the global plan for patient evaluation and management in real time. Tasks should be assigned and all resident encounters must be presented to, and seen by the attending. Residents are not expected to take call or be assigned overnight duties for consultant services. Direct supervision and onsite indirect supervision is provided on all consult/subspecialty rotations.

- **Rapid Response Teams**: In some settings, the senior resident is responsible for leading the rapid response team. The senior resident is charged with communicating the current status with the critical care team, and/or specialists when clinically indicated. The rapid response team is responsible for the immediate evaluation and management to include following the response to medications and evaluating stat orders such as portable chest x-ray. Depending on the patient's primary team, the rapid response team MAY NOT be responsible for the ongoing care of the patient beyond the initial stabilization period. The RRT is expected to provide verbal handoff to the primary team. In addition to the specialists mentioned above, the senior resident shall contact an in-house Hospitalist (both Faculty and non-teaching available by day, non-teaching at night) in situations that present a degree of medical complexity beyond his/her level of comfort and experience.

- **Code arrests**: At the VA code arrests are run by the ICU on-call resident, and at BUMC-P, the intensivist and/or fellow. The ward resident responds to codes at night at the VA and for their patients at BUMCP and is available for procedures or other assistance.

- **Cross coverage**: Cross-coverage of patients from the teaching service will initially be with direct supervision and then to indirect with direct immediately available. All residents are expected to physically go to the bedside to assess a patient if the nurse asks or if there are any worrisome

aspects of the call. All patient interactions on call mandate a note in the chart and communication with the primary team either on the check-out sheet or in person the following morning.

- **Ambulatory Clinics**: Residents see patients in the clinic under the direct supervision of the clinic attending, as well as with onsite indirect supervision. The clinic attending must be on-site for the residents to be evaluating and treating clinic patients. PGY-1 residents in the first half of the academic year must be directly supervised by the clinic attending. PGY-1 residents in the second half of the year and PGY-2 and 3 residents may see patients with onsite indirect supervision. The resident shall present all clinic patients to the clinic attending. The plan of care should be clear and agreed upon by both parties. Bedside evaluation by the clinical attending will be made on a case by case basis at the discretion of the clinic attending.

- **Procedures**: Residents must present risks, benefits, and alternatives to the patient when performing procedures (exception- emergent conditions, comatose pt). Written permission should be obtained from the patient on the appropriate consent form. All procedures must be documented. All residents require DIRECT supervision with procedures until they are signed-off by the program director in New Innovations. Once signed off, residents may perform procedures with onsite indirect supervision.

COMMUNICATION EXPECTATIONS:

Detailed communication and professionalism expectations are in another section of this manual and included in the milestones. However, highlighted expectations as they relate to supervision are that residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care and that Interns or Residents from a team are required to notify an attending in the following circumstances:

Critical patient events requiring prompt (typically within 1 hour) attending verbal communication:

- New admission to the hospital during the daytime hours
- Transfer to a higher level of care
- Development of significant changes in clinical condition requiring urgent or emergent interventions
- Medication or treatment errors requiring clinical intervention
- Procedures- for discussion of the planned procedure, patient characteristics and experience/competence of the potential operator. No procedures can be done without direct supervision until at least 3 successfully completed procedures are documented in new innovations.
- Code arrest or unexpected death

Non-critical patient events requiring daily attending verbal communication:

- Follow-up (diagnostic work-up and therapeutic management)
- Discharge plans of patients
- Transfer to a lower level of care
- Change in code status
- New consults

In the case of an emergency, any resident may attempt to accomplish everything possible to save the life of a patient or to save a patient from serious harm to the extent allowed by his/her license and/or within the scope of his/her level of experience, regardless of having documented privileges. An emergency is defined as a condition from which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Other than in the case of an emergency, the program will utilize disciplinary action for residents who perform or supervise procedures outside the scope of certification and privileging.

V. EDUCATIONAL CURRICULUM: ROTATIONS AND CONFERENCES

GENERAL DESCRIPTION OF THE CURRICULUM:

The Internal Medicine program curriculum has been carefully planned to provide the structured educational and clinical experiences necessary for residents to develop clinical competency in inpatient, outpatient and subspecialty areas of internal medicine over the course of 36 months. Residents begin with core inpatient and outpatient rotations and are given progressive responsibility and autonomy over the 36 months of residency. Continuity clinics begin in the first month of training for categorical residents and interns, which are maintained for the duration of the program. Each resident must complete 130 sessions in the continuity clinic during their 3 years of training and at least one third of the total experience in the program is in the ambulatory setting.

Residents are provided with a curriculum description that includes goals and objectives for each rotation through New Innovations and the latest curriculum manual. Progressive responsibility for patient care, teaching and supervision is assigned during inpatient ward and ICU rotations at B-UMCP and the VAMC based on demonstrated competence. If a resident has a special interest, a unique elective experience can be designed with Program Director approval.

REQUIRED ROTATIONS AND "CORE" ELECTIVES

The Program follows the ABIM policies and residents must meet the ABIM criteria for certification in order to successfully complete the program. The detailed requirements may be found at http://www.abim.org/certification/policies/imss/im.aspx. Selected portions are included below in italics:

> *"To be admitted to the Certification Examination in Internal Medicine, physicians must have satisfactorily completed, by August 31st of the year of examination, 36 calendar months, including vacation time, of graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACGME). 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. "*

See section on "Deficits in Required Training Time" for additional details related to time away.

In the 3-year internal medicine residency there are required rotations. The required rotations, along with the year they are *usually* completed, are as follows:

- Emergency Medicine (PGY-1)
- Geriatrics (PGY-3)
- VA Consultative Medicine (PG-2 or 3)
- Cardiology (any)
- Neurology (any)
- Three Ambulatory Months: Two at the site of continuity clinic and one ambulatory selective.

Regarding *electives*, the following rules apply (see appendix 7 for more details):

1. See the rotation selection guide for the area you are interested in.

2. At least 4 electives must have an outpatient focus

3. Special approval is necessary to complete more than 3 electives in one specialty

Residents are required to go over the goals and objectives for the rotation at the beginning of each rotation. These are sent through New Innovations at the start of every month.

AWAY ROTATIONS

Any elective outside of the Phoenix Metro area OR during which time the resident is excused from continuity clinic or required conferences, is considered an "away rotation". During the away elective, the resident is excused from program conferences, continuity and subspecialty clinics. Residents who meet criteria may be approved for no more than one month per entire residency during the PGY3 year (or PGY4 for Med Peds) unless the purpose of the elective is an "audition rotation" with a fellowship and then may be approved during the second year. Other circumstances may also be considered for exceptions and should be discussed with the program director. Away electives **may not be done in June** of the senior year.

"BETTER" CURRICULUM

Senior residents participate in a curriculum spanning two weeks per year in the PGY2 and 3 years. This 4 week curriculum is dedicated to improving patient care and individuals through research and quality improvement projects, and experiences focused on professional development, advocacy, and humanism. Participation in all of the assigned activities is required and absences require written approval. All residents are required to have completed a project (research or quality improvement) and present it (locally or nationally) by the end of their training.

SCHOLARLY ACTIVITY

In addition to the projects as part of the BETTER curriculum all residents are required to:

1. All residents are required to have completed a project (research or quaility improvement) and present it (locally or nationally) by the end of their training.

2. Do the presentation for Journal Club grand rounds or equivalent. The resident must submit the summary presentation and a copy of the article to the residency coordinator to be placed in the resident file.

The program also encourages an environment of inquiry for residents and faculty by supporting additional research projects, case presentations (poster and oral), and presentations of at least 30 minutes on an evidence-based medicine topic. Requests for funding and time related to travel for presenting projects must follow the outlined policies for time off and funding.

All projects are required to have a faculty mentor who will review the materials prior to submission and printing and will be recognized on the poster or applicable submission. Residents and faculty will notify the program of any publications so that they may be added to the resident portfolio and reported.

BOARD PREPARATION REQUIREMENTS AND RESOURCES:

All residents are expected to pass their ABIM board exam at completion of training. Faculty will use assessments throughout training to determine individual resident preparedness and suggest individualized study plans. All residents take the ACP's In-Training Exam (ITE) every year as an opportunity to simulate a board exam and track their test taking and acquisition of medical knowledge. This exam is not used for advancement decisions and cannot be released to fellowships or job applications. However, ITE scores often correlates with medical knowledge ratings on monthly assessments, participation and completion of assigned readings for conferences, scores on academic half day test questions and other assessments of medical knowledge which will be used as part of a resident's overall rating and rating of medical knowledge.

The program has made numerous board preparation material available to meet a variety of learning styles and settings. The items marked with *are required for all residents and the others are available resources which have been purchased to help residents study. Residents identified to be at risk of not passing the ABIM exam based on their ITE score or other criteria are assigned additional requirements in the Supplemental Study Program (SSP) below.

- ***MKSAP Curriculum for Non-Call Rotations:** The program has purchased a digital MKSAP subscription for all categorical and Med-Peds residents. When residents are on non-call rotations, they must complete the corresponding MKSAP section, including both text and questions, in addition to any curriculum assigned by their rotation preceptor.
    - At least 100 questions (or all of the questions in the section if there are less than 100)
    - <u>Which section?</u>
        1. The MKSAP that corresponds with the rotation (see table in Appendix 14 for the non-call rotations and requirements).
        2. If there is no required section or the section has already been completed, the academic half day topic of the month should be completed instead.
        3. If both have already been completed previously and there is evidence in MKSAP tracker (or PDF), then there are no additional requirements. The resident is encouraged to study whatever topic is most important to them.
    - <u>By when?</u> Monday of intern switch at 8am for both residents and interns. A report will be run through MKSAP on the Friday prior to the switch. On that day, any residents who haven't yet completed will be notified and have the weekend to complete it prior to invoking any of the consequences listed below.
    - <u>How to get the most out of this?</u> Residents are encouraged to review and provide answers to all missed objectives and to take notes in their "Board basics book" or another place for notes
- ***Academic Half Day weekly board prep questions and end of the month tests:** Each week in AHD, the session starts and ends with board style questions based on the objectives and pre-reading. At the end of the month, there will be a test on the topics and articles of the month.

- ***Academic Half Day learning objectives:** All Categorical and Preliminary Medicine PGY1s must submit the learning objectives for Academic Half Day on a weekly basis. They must be emailed to prior to 9:00AM on the morning of AHD. The only exception to this rule is when the resident is on vacation or on Banner ICU. Interns who will be off or on nights will need to plan in advance to complete as the submission is still required.
- ***Ambuatory PEAC modules** during all non-call months as assigned
- ***Mock ABIM exam:** All PGY2 and graduating residents are required to take this and to participate in the corresponding review session.
- **End of the year board review series:** The program provides graduating residents who choose to attend the local 6 day board review program with coverage of their clinical responsibilities and pays the $1,045 tuition for residents meeting the above requirements.
- Numerous additional books have been purchased and are available in the B-UMCP library for review**.**

SUPPLEMENTAL STUDY PROGRAM (SSP):

All residents who score below the 35th percentile on their in-training exam have the following requirements in addition to those listed above. See the detailed descriptions below the table

	Meeting	***Non-Call MKSAP 80% correct***	***Quarterly cumulative exam***	***Missed ITE objectives***	***Other***
PGY1	***APD advisor***	***X***			
PGY2	***APD advisor + PD***	***X***	***X***	***X***	
PGY3	***APD advisor + PD + learning specialist***	***X***	***X***	***X***	***All MKSAP completed and outlined prior to Awesome Board Review***

Descriptions:

- ***Meeting:*** To review current study plans and way that they are organizing information. Resident should bring their current binder, books, computerized material, etc for detailed discussion about effective strategies and barriers

- ***Non-Call MKSAP at least 80% correct:*** When completing the monthly 100 MKSAP questions for non-call months as above, residents should study the answer options prior to answering to help assure that their answer is correct prior to answering and then review and re-answer those they miss to reinforce learning.

- ***Quarterly integrated exam assigned through MKSAP.*** The test must be taken within 10 days of being assigned. Within 20 days of being assigned, the resident must schedule a phone or in person meeting with their APD advisor to review the exam and progress in achieving medical knowledge goals.

- ***ITE Objectives:*** Submit notes from the review of missed ITE objectives by February 28th following the ITE to the APD advisor and Jane Sanborn.

ACADEMIC HALF DAY:

- During Academic Half Day, the attendings will care for all patient issues and the ward attending must hold resident pagers during conference.
- The conference starts at 9:15 am (announcements) and ends at 12:30 pm. Attending physicians are expected to provide residents the time and space to attend this conference for the full duration. Please contact your Faculty Education Scholar if you are having trouble fulfilling this program requirement.
- **Residents must attend *every session for Academic half day in its entirety***
- There are objectives prepared for each lecture. All residents are expected to review the objectives and read posted articles prior to AHD.
- Pre and post questions and end of the month tests are designed for resident self assessment and reinforcement of key concepts related to the topic of the month
- Any absence other than those listed below must be explained in writing on the day of the missed session to Dr. Shinar (email brenda.shinar@bannerhealth.com) or a chief resident. An unexcused absence is a violation of professional conduct.
- The ***only*** residents excused from AHD are on the following rotations:
  - BUMC-P ICU, and VA ICU
  - Vacation
  - Night float
  - Ward residents who had to use a Tuesday for a day off (this only happens when approved by the chiefs)
  - Excused absences that have gone through the schedule request, chiefs or sick call procedure.
  - Heme/Onc at MD Anderson

OTHER CONFERENCES:

Our didactic conferences have been carefully planned to supplement clinical experiences. If a patient care issues arises, one member of the team should deal with it. Attendance is recorded at all conferences and residents are required to sign in. Excessive absences or dishonest reporting of attendance will be considered a violation of the professionalism policy.

1) Morning Report

- Resident morning reports are scheduled for Mondays, Wednesdays and Thursdays from 11-12 in Classroom C at BUMCP and from 12-1 in Room C425 at the VAMC. It is expected that all ward residents and interns attend, be on-time and participate in the discussion unless on night float or post call.
- Residents are expected to be prepared with detailed knowledge of the case including labs, EKGs and imaging.
- Residents are also expected to use multiple evidence-based resources for the teaching points – not just UpToDate.
- The presentation should not be a full lecture on the topic but rather a focused, case-based discussion with emphasis on the 3 things that the resident selected to emphasize.
- Detailed instructions and tips on how to organize the case, present it, and interact with your audience are available on the uaphxim website.

2) Patient Safety and Quality Improvement Conference

This is held once per month and is organized by the VA internal medicine chief residents. It is usually scheduled for the fourth week of the month (pending holidays). It is at 11AM in Classroom C at BUMCP on Wednesday of that week and at 12PM at the VAMC on Thursday of that week.

3) Wednesday Conferences at BUMCP and the VA
Various conferences occur from 12-1PM throughout the month. All residents (ward and non-call subspecialty months based at the site but not ICU) are expected to be present on time and signed in unless they are on night float or post call. There will be no 11AM morning report when there is a noon conference scheduled for the same day.

4) Grand Rounds
Grand Rounds are held each Friday. They run from 8-9AM in the amphitheater at BUMCP and are streamed via video at the VA. Presenters come multiple different specialties and backgrounds within our own institutions as well as from different health care systems from around the country.

Attendance at one of the sites is required for all residents unless on an away rotation, on ICU, post call or off. Categorical IM residents with a Friday morning clinic have had the start time of clinic adjusted (9am-1pm) to allow attendance at grand rounds prior to going to clinic. Residents on non-call rotations are required to attend one of the grand round sessions which is most convenient for them.

ADDITIONAL PLANNED EDUCATIONAL SESSIONS:

- **Retreats:**
  - Resident as teacher Part 1: Intern Retreat: On or around Veteran's Day All interns (preliminary medicine, categorical and Med-Peds) gather at the home of a faculty member to discuss stress management, team work, teaching medical students, patient safety principles, fatigue and sleep, and other content selected by class representatives.
  - Resident as Teacher Part 2: How To Be A Great Resident (HTBGR): Prior to completion of internship and early in the PGY2 year, residents participate in workshops focused on teaching and leadership, as they transition to the role of senior resident.
  - PGY2 Retreat: Annually in March. Focused on career development (interview skills and writing a CV), team building, wellness, and teaching skills.
- **Simulation Center**: The curriculum includes educational time in the Simulation Center to learn proper techniques for codes and procedures such as intubations and central lines, simulation of common inpatient emergencies and a variety of other cases. All residents are expected to complete assigned readings and pre-tests prior to all simulation center experiences.

VI. PROCEDURAL SKILLS

The following requirements are based on the ABIM guidelines at
http://www.abim.org/certification/policies/internal-medicine-subspecialty-policies/internal-medicine.aspx

Safety is the highest priority when performing any procedure on a patient. The American Board of Internal Medical (ABIM) recognizes that there is variability in the types and numbers of procedures performed by internists in practice. Internists who perform any procedure must obtain the appropriate training to safely and competently perform that procedure. It is also expected that the internist be

thoroughly evaluated and credentialed as competent in performing a procedure before he or she can perform a procedure unsupervised.

For Certification in Internal Medicine, the ABIM has identified a limited set of procedures for which it expects all candidates to be competent with regard to their knowledge and understanding. This includes (1) demonstration of competence in medical knowledge relevant to procedures through the physician's ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management, proper techniques for handling specimens and fluids obtained, and test results (2) ability to recognize and manage complications and (3) ability to clearly explain to a patient all facets of the procedure necessary to obtain informed consent.

In order to assure adequate knowledge and understanding of the common procedures in internal medicine, **each resident should be an active participant (not necessarily primary operator) for each required procedure five or more times**. Active participation is defined as serving as the primary operator or assisting another primary operator. For a subset of procedures, ABIM requires all candidates to demonstrate competence and safe performance by means of evaluations performed during residency training. The set of procedures and associated competencies required for each are listed below:

Competency is required in the following procedures:

	Know, Understand and Explain				Perform Safely and Competently
	Indications; Contraindications; Recognition & Management of Complications; Pain Management; Sterile Techniques	Specimen Handling	Interpretation of Results	Requirements & Knowledge to Obtain Informed Consent	
Abdominal paracentesis	X	X	X	X	
Advanced cardiac life support	X	N/A	N/A	N/A	X
Arterial line placement	X	N/A	X	X	
Arthrocentesis	X	X	X	X	
Central venous line placement	X	X	N/A	X	
Drawing venous blood	X	X	X	N/A	X
Drawing arterial blood	X	X	X	X	X
Electrocardiogram	X	N/A	X	N/A	
Incision and drainage of an abscess	X	X	X	X	
Lumbar puncture	X	X	X	X	
Nasogastric intubation	X	X	X	X	

Competency is required in the following procedures:

	Know, Understand and Explain				Perform Safely and Competently
Pap smear and endocervical culture	X	X	X	X	X
Placing a peripheral venous line	X	N/A	N/A	N/A	X
Pulmonary artery catheter placement	X	N/A	X	X	
Thoracentesis	X	X	X	X	

Because of our dedication to patient safety as the highest priority when performing any procedure on a patient, our program has deemed it a priority to provide each resident with sufficient opportunity to be observed as an active participant in the performance of required procedures. In addition, we have created numerous opportunities to complete initial or additional training in procedures through the use of simulation.

- Residents must contact the attending to coordinate any invasive procedures so that s/he can be physically present during the procedure if at all possible for patient safety purposes (regardless of whether there is a resident present who has successfully completed enough procedures to be considered competent).
- In the event an attending physician is unable to supervise, the level of supervision will be determined through individual conversations between the supervising attending and resident based on patient, procedure, resident experience/confidence and urgency of the situation.
- The ABIM recommends, and our program mandates, that each procedure be performed successfully as the primary operator with direct supervision (attending present, observing the entire procedure) on at least three separate occasions before being considered to perform with indirect supervision (attending immediately available if needed).
- Residents who do not yet have documented (in New Innovation) competence in a procedure, must seek out support and supervision. If the primary attending is unavailable, they must seek supervision by an alternate attending or more experienced resident. Specific procedures that are high risk have specific supervision requirements. All oral or nasal intubations at BUMC-P must be supervised by trauma anesthesia, a pulmonary fellow, or one of the intensivists. At the VA, only practitioners who have been trained in out of operative room airway management may intubate, even when supervised.

Additionally, being able to perform any given procedure safely and competently includes the following procedure requirements:

- Knowing, understanding, and being able to explain the: indications and contraindications of the listed procedures, requirements and components of informed consent, interpretation results of these tests, complications and be able to initiate management (Appendix 4).

- Effectively explaining the indications, contraindications, and possible risk and complications to the patient (or available surrogate, if the patient is not able to provide informed consent) so that they

might provide informed consent. The nurses should never be asked to obtain consent, because they cannot explain the risks and benefits of the procedure - crucial factors of an "informed" consent. If the patient has impaired decision-making ability, the person holding medical power of attorney should give consent. If the patient does not have a medical power of attorney or they are unavailable, then a surrogate decision-maker must be found. In the state of Arizona, the order of decision-makers is spouse, adult children, parents, siblings, domestic partner and then close friend. At the VA, the algorithm for contacting and documenting a conversation with a surrogate decision maker must be followed.

- Time Outs are required prior to every procedure. Performing a "Time out" includes: Collaborating with the patient to identify the patient with at least 2 identifiers, confirm the correct procedure (including location), confirm that the correct consent has been obtained and confirm that the correct materials are immediately available prior to beginning a procedure.

- Nurses and/or attendings will check resident logs in New Innovations when necessary to confirm documented ability to complete procedures with indirect supervision.

- Select the setting for the procedure that optimizes efficiency, safety, and resident education.

- Procedures notes must be written after every procedure. The components of a proper procedure note include: indication, informed consent obtained, time out completed, names and functions of each physician involved, supervising physician (resident or attending and if they were directly present or indirectly supervised), pertinent physical findings (i.e., Allen test when performing radial arterial cannulation), anesthesia, sterile technique and anatomic location of procedure, any specific data obtained (i.e., opening pressure on lumbar puncture), complications, and planned follow-up.

  All procedures that are performed (even after the resident has achieved the threshold numbers) should be documented in New Innovations prior to the completion of the rotation. See APPENDIX 5: HOW TO LOG PROCEDURES INTO NEW INNOVATIONSfor instructions on logging procedures in New Innovations.

VI: DOCUMENTATION, AND COORDINATION OF CARE

CHARTING RESPONSIBILITIES

Residents are responsible for reviewing all clinical information and notes of other physicians and ancillary staff regarding their assigned patient.

Although copying prior notes may help to save time and track changes, it is unacceptable to leave unedited or outdated information. Every single chart entry must be signed and include the resident pager number and name of the supervising attending for the day. Additionally, notes must be correctly time-stamped, including the date and time that the patient was physically seen.

- **H&P.** The intern completes an H&P using the appropriate template**.** An appropriately comprehensive Review of Systems (ROS) and physical exam (PE) must be completed and documented (see billing and coding requirement in the IM Housestaff Pocket Book). The

resident thoroughly reviews the intern note to assure accuracy and writes a separate short note, documenting a **brief** HPI, pertinent exam and correction of potential deficiencies in the findings of the intern, assessment, and plan. In general, it is insufficient to write that the patient was 'seen and examined'. The resident is expected to review and make changes to orders as needed and supervise the intern appropriately to advance the intern's education and ensure the highest quality patient care. These need to be finalized within 12 hours of admission.

- **Daily progress notes.** These are the primary responsibility of the **intern** unless the intern is off. The resident should, however, at least read and give feedback about the intern notes each day. If significant information is left out of the intern note, it is expected that the resident addend the note to make it more complete. At times, residents may need to write the progress note to facilitate patient care and assist in the team's daily tasks.
- **Follow up notes:** Return visits to a patient must be documented as a follow up note or addendum to the prior note. Examples of return visits that necessitate documentation include: to follow up on a patient's improvement, change in the plan of care based on discussion with the attending or consultant, or a new complaint/concern.
- **Cross Cover:** A brief note must be entered describing the current subjective and objective information and assessment and plan.
- **Orders:** Residents are responsible for placing their own orders into the computer. If telephone orders are given to a nurse, those orders will be sent to the inbox and must be signed within 24 hours. Verbal orders (that is, an order told to a nurse in person without being input into CPOE) should only be used during an emergency.
- **Consults:**
    - When requesting a consult, the consulting physician/team must be called personally to discuss the patient and ongoing communication is expected for regular coordination of care throughout the hospital stay.
    - Residents serving on a consulting team, will complete an initial consult note and daily progress notes. Initial and follow up verbally communication is expected regular coordination of care throughout the hospital stay.
- **Discharge Summaries:**
    - **BUMC-P:** Patients with a diagnosis of heart failure must have discharge summary completed at the time of discharge, though this practice is strongly encouraged for all patients. Discharge summaries must be completed within 24 hours. Edited and "finalized" summaries should be forwarded to the attending that supervised the patient's care on the day of discharge.
    - **VA:** At the VA, the discharge summary needs to be completed within 3 days. Additional details are available in the orientation packets and below in the delinquent records policy.
- **Preliminary Cause of Death and notification of family:** Death summaries are to be dictated just like a discharge summary, but a preliminary cause of death note is required at BUMC-P. A note indicating that the family was notified and offered an autopsy is required at the VA.

DELINQUENT RECORDS POLICIES

Good patient care and good practice management calls for timely documentation and confirmation of orders. VA and BUMC-P policy requires that all discharge summaries be completed within 24 hours of discharge. A discharge summary is considered delinquent if not completed within 3 days from the time the patient is discharged. The in-box in Cerner and VA needs to be cleared weekly or within the timeframe specified in orientation materials.

Periodic updates on the status of medical records are forwarded from the BUMC-P and VA medical records departments to resident email addresses and should be addressed as soon as possible. Violations of documentation requirements will be handled according to the professionalism policy.

PATIENT HANDOFFS

Patient handoffs occur throughout the patient's care and they must be completed safely and efficiently. A standardized "check out" form for each ward and ICU shift is used which includes important patient identifiers, patient's active problem list, medications, abbreviated hospital course and complications, anticipated problems overnight, and concise instructions for the on-call team.

- The "I PASS" method for written and verbal communication of information and patient handoffs is used to maximize patient safety and efficiency.
- The patient handoff must be face-to-face in a quiet environment except in rare cases where the receiving resident was briefly unavailable. If that occurs, the check out will occur verbally as soon as the receiving resident in available.
- Each morning there should be written and/or verbal communication with each team to provide an overnight report of any patient events.
- All cross-cover care that required a visit to the patients' bedside must be documented with a note in the chart in addition to a verbal check out given to the oncoming physician.
- At the end of a rotation or when a patient is transferring to another service, a written summary must be provided in the chart.

PATIENT SAFETY

- The program, faculty and residents must actively participate in patient safety systems and contributes to a culture of safety at all clinical sites. Residents are expected to comply with all policies and make every effort to constructively engage in quality improvement and patient safety initiatives at the clinical sites.

- Knowledge and compliance with the infection control policies is mandatory for patient safety.

- Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes.

- Residents and faculty members are required to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

- Residents must complete all assigned formal educational activities that promote patient safety-related goals, tools, and techniques.

- Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Residents and faculty members must know how to and report patient safety events at each clinical site and within the program.

- Residents and faculty members must review the annual summary information of the hospital patient safety goals.

- All residents must participate in the training on how to disclose adverse events to patients and families as part of the BETTER curriculum.

NON-TEACH PATIENTS

Residents are not responsible for covering non-teach patients at BUMC-P or the VA other than in the course of their roles on the code and rapid response teams. In the event that a nurse contacts a resident due to an urgent concern with a non-teach patient, the resident is expected to respond and care for the patient and later report it to the program director or attending.

AUTOPSIES

An autopsy is a unique opportunity for learning and there are policies to support offering this to families.

- BUMC-P: Families may be offered an autopsy at the time of death. A first-degree family member must sign the request for autopsy and mortuary transport forms. There is no additional charge to the family for an autopsy. Autopsies are performed at B-UMC Tucson and reports made available in Cerner within 1-2 weeks.
- The VA Policy states that a post-mortem examination must be requested for all patients who expire. This request and the decision of the family must be documented in the death note, with the following exception: in the event that a cross-cover patient dies overnight, it is the responsibility of the on-call physician to notify the patient's family and to alert the primary team the following morning. The primary team will be expected to contact the family the following day to request autopsy and if granted, will be notified about the time of the autopsy. Any questions or potential exceptions must be discussed with a faculty attending.

VIII. COMMUNICATION AND PROFESSIONALISM

PAGERS and RESIDENT AVAILABILITY

Residents must be available by pager from 7:00 a.m. to 5:00 pm unless on vacation, nights or a day off in order to allow clinic staff, the secretaries, and the chief residents to contact them. This includes weekend shifts that residents are working and allows for consulting physicians and nurses to discuss patient care and orders. Failure to respond to pages during these hours is considered a violation of professional accountability. Residents are encouraged to turn off their pager outside of these hours to allow for appropriate rest.

The typical hours are modified for clinical shifts that are overnight as a part of the Emergency Medicine, wards, night float or assigned ICU shifts. During those shifts, residents should keep the pager on during the shift and then turn it off when the shift is complete.

Additional availability expectations are specifically outlined in the section on back up call.

- At BUMC-P wards, amion.com is used by residents, attendings and nurses to reach the proper resident for a team. The password is "bgsmcim all" for members of the residency program and "bgsmcim" for nursing staff.
- The electronic text-paging system is accessed on the intranet under "paging tool". Individuals on that system are searched by last name.
- Pagers are secure and may include patient protected information.
- Cell phones may not be used to text patient information. Any patient identifiers including location, name, or other identifying info are not to be included.

- If called incorrectly, residents are expected to assist the caller to find the correct individual.

PROGRAM EMAIL

Each resident has been assigned a secure email that allows for communication of HIPAA protected information and official program and employer communication. All house officers will be required to check their e-mail with enough regularity to stay informed about patient care follow up, assignments, deadlines and rotation expectations. Failure to check e-mail will not serve as a valid reason for not knowing the content of official notifications.

Sending Banner Health related patient information can only be done between a bannerhealth.com email addresses of the intended parties. Employee e-mail address will not be made available to the public.

TEAM ROOMS/CALL ROOMS/EXERCISE AREA

BUMC-P has call rooms with computers, a kitchen, and an exercise facility. At the VA, the call rooms and team rooms similarly provide a workspace for resident convenience and place for rest. All papers and printouts must be disposed of using HIPAA-compliant methods.

Lockers are available in several locations at BUMC-P and the VA, residents are expected to provide their own locks.

COMPUTER USAGE

- In each work area at BUMC-P and the clinic, residents will find a computer, and printer connected to the Internet. A direct connection to the Internet allows residents to access Up-to-Date and the Arizona Health Information Network (AzHIN). This network provides links to PubMed, OVID, and many medical texts, clinical journals, and practice guidelines. The librarians on staff there are experts and can help with evidence-based searches and questions.
- Computer problems and clinical informatics questions at BUMC-P can be addressed by calling the IT helpdesk at (602) 747-4444, option 3.
- The Team Room computers access the internet through the hospital's LAN network .
- The program provides all residents with password protected external storage devices for use during their training if requested but it must be turned in when employment ends.
- No patient identifiers should be stored on an external storage device and these are not allowed at all at the VAMC.
- HIPAA requirements are to be followed at every educational site.

VII. DUTY HOURS AND THE LEARNING ENVIRONMENT

Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the assurance of their fitness for work, including management of their time before, during and after clinical assignments, and accurate reporting of clinical and educational work hours and patient volumes. Residents and faculty are also expected to be pro-active in maintaining their health and wellness through the utilization of program resources and self-reflection.

RESIDENT DUTY HOURS

The program is committed to patient safety and adhering to the ACGME duty hour limits with regard to the schedules and expectations by faculty and residents. Through accurate reporting and the pro-active attention to duty hour limits, the program, residents and faculty will together assure program compliance.

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

a. Duty hours must be limited to 80 hours per week when averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.
b. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
c. Residents should have 8 hours free of duty between scheduled duty periods.
d. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
e. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. No new patient care assignments may be made or accepted during that time.
f. In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site to continue to provide humanistic attention to the needs of a patient or family or attend unique educational events. These additional hours of care or education will be counted toward the 80 hour weekly limit.

Duty Hour Logging Compliance Process:
All duty hours are to be recorded for ICU and ward rotations. The most accurate recording is real-time and so residents are encouraged to log daily.

Reporting for non-call rotations are by exception so that daily logging is not required but any resident that identifies any violations must be reported through duty hour logging or a program issue of concern. Logging compliance is checked in an on-going basis and reminders sent if resident is delinquent.
Duty hour logging compliance reports are part of the CCC review. Any duty hour violations are reviewed initially by the program director or designee. The PD reviews each violation and then either approves the cause or reason ("justification") submitted, declines the justification, or, if a justification is not given, asks for more information.

The Duty Hour Compliance Report is generated in New Innovations on a monthly basis. For recurrent or unjustified violations, the PD initiates direct or systemic changes to minimize violations. Violations are discussed with the chief residents during the weekly meeting and the Associate Program Directors as needed. An action plan to address new or recurrent violations is then generated with follow up as part of the Program Evaluation Committee. Such changes and interventions include directly contacting the Attending of record for further education, changing resident hours/rotations or adjusting the volume of work being performed during the given hours.

When on back up call, chief residents will monitor the frequency in which residents are called in to assure rest, duty hour compliance, and reasonable personal time. Residents on back up call will have 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

MAXIMUM PATIENT VOLUMES

The program is designed to provide a supportive environment in which resident education is maximized through the combination of structured didactics and supervised clinical experience. The provision of service to our patients is a vital component of education and are committed to working well within the ACGME guidelines to strike the right balance between patient care and education.

The definition of in-house transfers are ICU transfers, night float handoffs and other handoffs/transfers where the H&P has already been written by an attending or resident on the teaching service.

First year residents:

- No more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers .
- No more than eight new patients in a 48-hour period (does not apply to Night Float Rotation)
- Provide ongoing care to no more than 10 patients

Senior residents:

- When supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period.
- When supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients.
- When supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients

Night Float:

- Interns may admit a Maximum of five admissions/consults per 24 hours + 2 in-house transfers. (Note: There are no specific program requirements for consult numbers, but the program considers this the same as an admission).
- The supervising resident may supervise or admit a maximum of 10 new patients in an admitting day + 4 inpatient transfers. Therefore, the resident may supervise five intern admissions and admit another five patients without the intern. The supervising resident may also supervise or admit up to four additional "transfer patients.”

Other:

- Appropriate duty hours, service to education ratio, and patient safety are of utmost concern and are monitoring during all rotations.

- Violations of patient care caps or perceptions of excessive service over education must be reported to the program director.

CONFLICT OF INTEREST:

Residents will not be responsible for caring for their family or close friends. If a potential conflict of interest will occur or is identified, the resident will call the chief resident sick call pager to develop a plan for back up. Separate policies exist for HIPAA and resources are available to address any questions at each clinical site. Residents are not to look up clinical information for patients that they don't have a formal role or responsible for.

No resident or attending is to evaluate a trainee who they may have a conflict of interest with based on personal or family relationship.

WELLNESS AND FATIGUE MITIGATION:

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician.

Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Our program, in partnership with the UA COM-P is committed to addressing and evaluating well-being as they do to evaluate other aspects of resident competence. Faculty and residents are educated to recognize the signs of fatigue and sleep deprivation, fatigue mitigation

Residents and faculty members are encouraged to alert the program director when they are concerned that another resident, fellow or faculty member displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.

Residents and faculty members must demonstrate an understanding of their personal role in the assurance of their fitness for work, including:

1. management of their time before, during, and after clinical assignments; and,

2. recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team.

3. accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider and or calling in back up support for clinical responsibilities. In the event that this occurs, it will have no negative consequences for the resident who is unable to provide the clinical work.

Fatigue Mitigation:

All residents will participate in education about recognizing the signs of fatigue and sleep deprivation during orientation and prior to any rotation with extended shifts. The orientation includes information about alertness management and fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

In the event that a resident is unable to perform their patient care responsibilities due to excessive fatigue, the same procedure for medical illness or other unanticipated personal emergencies will be followed:

1. Resident alerts their supervisor (senior resident if PGY1 and attending if PGY2 or higher) to either assume the clinical responsibilities or plan for transfer of care to back-up.
2. Notify the chief resident by calling the sick call pager for coverage to be arranged.

Additionally, the program and institution ensure that there are adequate sleep facilities available and also provide reimbursement for the use of transportations for residents needing assistance due to fatigue because of time spent on duty.

Well-Being Resources:

Residents and faculty are also expected to be proactive in maintaining their health and wellness through the utilization of program resources and self-reflection.

The most up to date and comprehensive list of well-being resources can be found on www.wellness.arizona.edu. The following is a summary list of some resources provided by the program

- Free health insurance which includes behavioral services.
- All residents have free behavioral health visits through the Employee Assistance program
- Free On-site work out facilities at BUMC-P
- BUMC-P has an ECHO/Wellness program that offers massage, acupuncture, and other integrative services on-site for a nominal fee. They also provide bonuses for assessments of clinical measures (blood pressure, etc).
- Resident retreats
- The chaplain services at BUMC-P are available for discussing the effects of critical incidents or stressful events and can be reached through their on-call pager 817-8113.
- All house officers receive a meal card to pay for meals when **on call** at BUMC-P. When the cafeteria is closed, food is made available to residents in the lounge next to the cafeteria. At VAMC, the doctors may receive breakfast, lunch, and dinner *at specified meal times* throughout the day. All other vending machine and cafeteria costs are the responsibility of the house officer.

Any resident that feels unsafe driving home after work must either sleep in a call room until they are safe to drive OR arrange a ride. Medical Education will reimburse for the cost of a cab or ride-sharing service. Submit receipts to Arletta Espinoza or Diane Ramirez.

PROFESSIONAL APPEARANCE:

In addition to details of the Banner Health employee manual, the following specifics are highlighted for residents in our program.

- Professional attire or scrubs with a white coat or program specific embroidered coat must be worn in all patient care settings.
- Jewelry and fingernail must not interfere with patient care and the ability to do an appropriate physical exam.
- Shoes must be closed-toe and non-porous). Sandals are not to be worn in any patient care area.
- Odors which may interfere with the health of the patient are not permitted. This includes heavily scented colognes, perfumes, body lotions, and cigarette smoke odor.

VIII. SCHEDULING:

All residents are required to be physically present on rotations as assigned. Any absences must be arranged through the defined procedures listed below. Not following these procedures is considered a violation of professionalism expectations and job duties and may result in disciplinary action or limit future schedule requests.

SWITCH DAYS

Switch days are planned far in advance and coordinated with other programs. In general, Interns switch on a Monday toward the beginning of the month and Seniors on the Wednesdays. With holidays, these are adjusted. This schedule has been designed to assure safe patient handoffs and transitions.

REQUESTS FOR EXCUSED ABSENCES AND SCHEDULE CHANGES

Every change to the schedule or special consideration takes time and resources and has potential unanticipated consequences that individual attendings and residents won't necessarily be able to appreciate. For those reasons, the program has established processes that all residents are expected to follow. Failure to follow these expectations will result in the absence being unexcused and considered a professional conduct violation.

- All requests for excused absences and schedule changes must be via the on-line schedule request form. Verbal or email communication is not sufficient. If there are important additional details that need to be included, an email should be sent to martha.brion@bannerhealth.com. Individual attendings do not have the authority to grant schedule changes or additional days off.
- An emergency (less than 7 days), requires both a text to the sick call pager (602-201-1881) AND completion of the on-line schedule request. Daily updates should be provided via the same mechanism if the health issue leading to an absence extends beyond one day.
- If any change will affect back-up call, the resident is responsible for finding coverage, completing an online schedule request form (including all information related to covering resident).
- Consideration of written schedule request that include one resident covering for another for a work-related excused absences will only be considered if the covering resident does not have has continuity clinic and only after all resident responsibilities are covered. Any payback must be on weekends or days that the resident would not have been scheduled to work.

- No schedule requests for specific teams, color, attending or call room will be considered given the complexity of accommodating the requests for days off.
- All requests for specific days off on call months and ED (for a conference, interview or other personal reasons) will not be granted if received less than 60 days prior to the rotation.

When considering schedule requests, the impact on colleagues, patient care and continuity, the number of prior requests and the rationale for the request will be considered. Details related to this are to be included in the form.

EXCUSED TIME AWAY FROM WORK:

Per the ABIM policies, up to one month per academic year is permitted for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities. Training must be extended to make up any absences exceeding one month per year of training with occasional one-month exceptions as granted by the clinical competency committee.

In the program, there are four specific ways that residents may have excused time away from work. These include:

1. VACATION DAYS:

Housestaff receive a total of four weeks of paid vacation. A week is defined as five consecutive weekdays and one adjoining weekend. These are scheduled on non-call months without ward supervisory or sick call duties unless additional coverage has been arranged.

2. SICK DAYS:

As per the UA COM-P GME manual, all residents have 40 hours of sick time per year. The specifics around how the time is accumulated and accounted for are listed in that manual. Sick time can be used for any type of health-related issue including physical, mental or preventative medical appointments. Schedule requests and notification of the on-call chief resident is required for this absence to be excused. In the schedule request form and text to the sick call pager, residents only need to say that they will not be able to come in for health reasons.

Residents who are sick or on leave for more than one week, must contact Arletta Espinoza to follow the occupational health policies for return to work.

3. FLEX DAYS:

When residents volunteer or are assigned to cover for a colleague on a night or weekend that they wouldn’t normally have been working (excluding coverage for program sponsored events), they will be granted a FLEX day to be used for future flexible vacation time off. There are no limits on how this time may be used but it must be scheduled according to the absence request process above.

4. OTHER FAMILY MEDICAL LEAVE (FMLA) and LEAVES OF ABSENCE:

Extended time away for personal illness, maternity leave, care-giving responsibilities (family, paternity leave, etc) and bereavement. The program will discuss with individual residents the options of time without pay, utilizing vacation time or sick time as appropriate, and extending training with the resident to assure compliance with ABIM and employer requirements and meet individual needs.

EXCUSED WORK RELATED ABSENSES:

There will be several months throughout the year when special events occur, requiring many residents to attend even while they are on call months. In this instance, residents on non-call rotations will be pulled to cover the responsibilities of the residents attending the specific event. Given the high likelihood that coverage will be required by residents not on backup call, all non-call residents should expect to fulfill these duties when requested.

Specific program-sponsored events requiring multiple residents to attend include but are not limited to:

- ACP Conference (Fall, 2 days)
- In-Training Exam (Fall, 2 days)
- Intern Retreat (Nov 11, 1 day)
- PGY2 retreat (Spring, 1 day)
- Awesome Board Review (April/May, 6 days)
- How to Be A Great Resident (May or June, 1 day)
- Academic Excellence Day (May, 1 day)

Additionally, residents may be excused from their rotation assignments for specific educational or job requirement related activities. These include the BLS/ACLS renewal, taking USMLE/COMLEX Step 3 (not prep), presentation of their scholarly work, special conference attendance and other trainings.

Absences during assigned clinical shifts for conference related travel will be excused for the presentation day and appropriate travel time (max of one day to and from), other days away will be counted as vacation.

Any work-related absences that are not directly scheduled by the program, must go through the schedule request form in order to be excused.

CONFERENCE RELATED TRAVEL:

Residents are encouraged to submit posters/abstracts/clinical vignettes to competitions in medical organizations. Some of the frequently attended conferences are ACP (American College of Physicians), SGIM (Society of General Internal Medicine), and DDW (Digestive Disease Week). Absences during assigned clinical shifts will be Excused for the presentation day and appropriate travel time (max of one day to and from) other days away will be counted as vacation based on availability.

When available, funds may **partially** reimburse residents (generally up to $1500/year per resident) for the expense of trips that occur to present research or case vignettes on which they are the primary author or only presenter available. Residents are responsible for their own registration, travel itinerary, etc. and must complete the travel form 2-3 months prior to travel in order to be eligible for possible reimbursement of expenses.

BACKUP CALL

A backup system is in place so that if a colleague cannot fulfill his or her clinical responsibilities, a resident colleague assigned to "back up" would cover. Each resident and intern will be assigned as backup call during a non-call month. The duration of time as backup will vary from depending on the resident's schedule. All residents on backup call will be given one day off in 7 on average according to the ACGME duty hour rules.

Residents must stay in the Phoenix-metro area and be available by pager 24 hours a day and be able to return a page within 20 minutes during the entire time they are on backup call. Failure to return a page within 30 minutes is considered a violation of professional conduct.

Determining when the backup resident is called is at the discretion of the Chief Resident and the faculty attending, who will consider clinics, potential work hour violations, and previous coverage responsibilities**.** When possible, calling the backup person will be avoided by rearranging coverage of the other ward team members.

At the start of a rotation, the attending will be notified by the program of dates that a resident is on backup call and may be absent. The program will notify attendings when a resident has been called in to work as part of the backup call.

MOONLIGHTING

The Internal Medicine Moonlighting policy is covered in the UACOM-P House Staff Manual with the following additions:

- The Clinical Competency Committee and Program Director must approve the resident for moonlighting. Only PGY3 residents in good standing are permitted to moonlight. The purpose of this is to determine that the resident will be able to devote time to the moonlighting activity without jeopardizing his/her residency activities (e.g. coursework, clinics, weekend ward coverage, sick call and contingency call). An email describing the position and rationale may be submitted to Arletta Espinoza who will place it on the agenda for review.
- The CCC and the Program Director will not judge whether the resident has had sufficient training to manage the activities required the specific moonlighting job. It is the resident's responsibility to discuss the necessary skills with the prospective employer and determine with that employer whether the resident's prior experience and training is adequate for him/her to perform the expected duties in an unsupervised setting. The resident must determine whether additional malpractice coverage is required.
- Total in-hospital working hours, including <u>both</u> residency duties and moonlighting, may not exceed 80 hours weekly. Moonlighting may occur <u>only during non-call months</u>.
- Moonlighting clearance will be reviewed annually by the CCC to assure continued compliance with the requirements.
- Residents who scores less than the 35th percentile on the in-training Exam given each year will not be allowed to moonlight. So as not to create undue hardships, extenuating circumstances should be discussed with the program director.
- Failure to comply with these requirements or those of the UACOM-P House Staff Manual will result in disciplinary action.

IX. RESIDENTS AS TEACHERS

MEDICAL STUDENTS

As the major teaching affiliate of the University of Arizona College of Medicine – Phoenix (U of A), third-year students from the U of A perform their required clerkship in Medicine at BUMC-P and the Phoenix VA Medical Center. Fourth-year students from the U of A and other schools rotate on medicine as sub-interns as well as electives. Residents will have direct responsibility for medical student supervision, teaching, and assessment. Residents will attend several mandatory teaching workshops and conferences over the course of their three years of training to develop and hone their skills as educators and evaluators.

In general, beginning 3rd year students will see patients in conjunction with an intern while more experienced 3rd year students and 4th year students acting as sub-interns with their own patients work directly with the resident. Medical students should carry 3-5 patients. Third-year students should only take weekends off but fourth year students can take weekdays off if needed. Residents should provide regular informal feedback on the students' work including the written history and physicals, knowledge base, and clinical judgment. Residents are expected to assist the attending in completing a formal written assessment of their medical students.

Students may document the history and physical which was performed in the presence of the resident. Every medical student must be reviewed and updated by the supervising intern or resident. It will then be verified by the attending. Any additional days off (sick, appointments, interviews, etc) beyond the one per week and University holidays must be reported to the student coordinator in Medical Education for tracking. Faculty attendings should be contacted for questions or problems that arise.

For third year medical students at BUMC-P, when their team is on night float, they work Sun 4p-8a, Mon night off, Tues morning off, afternoon lecture at U of A, Tues night 6p-8a, Wed 6p-8a, Thurs 6p-8a, Fri off, Sat 6p-8a with the team. They will continue to round with the team attending during the week and will admit patients every night and follow up on the patients admitted from the evenings before. Each night they should write 1-2 progress notes on patients that they admitted during previous nights, these should be forwarded to the attending to review. They have one weekend day off per week.

Refer also to the Medical Student Clerkship Manual and Orientation materials available at http://phoenixmed.arizona.edu/education/degree-programs/md-program/curriculum/year-3-curriculum/clerkships/year-3-clerkships-4.

X. APPENDICES

APPENDIX 1: INTERNAL MEDICINE ROLES AND RESPONSIBILITIES BY POST GRADUATE YEAR **(updated 8/30/16)**

First Year:

- **By the end of the first year the resident will demonstrate the ability to supervise first year residents, medical students and demonstrate effective leadership skills. [MKnow, Prof, PracBLI]**
- Internal Medicine residents usually begin their residency immediately after graduating from medical school. As such, they are expected to perform a generic history and physical, establish a differential diagnosis, and create an initial diagnostic and treatment plan using basic concepts and principles learned in their several medical school core clerkships. [PCare, MKnow]
- In contrast to a medical student who participates in activities primarily to learn, the first year resident is expected to assume responsibility for the care of the patient. This means that s/he reports to the designated clinical setting at the proper time, dressed in appropriate attire, answers pages promptly, responds promptly to emergencies, sees patients in a timely manner, maintains good written notes in the chart, takes call as assigned, and contributes as a team member. [PCare, IPComm, Prof]
- The resident will demonstrate knowledge and use of policies and procedures of the departments through which s/he rotates at both BUMC-P and the Veterans Affairs Medical Center relevant to the care of their patients. Specific attention will be given to the appropriate use of restraints. [PCare, PracBLI, SystBP]
- On various rotations throughout the first year, operating in the ambulatory setting, emergency center and medical and surgical floors, the resident will demonstrate increasing fluency in basic patient management skills with multiple patients which include interviewing and physical examination skills gathering information relevant to the problem(s), writing orders and progress notes, obtaining and interpreting laboratory, imaging and other studies, such as electrocardiography. [PCare, MKnow, IPComm, ProbBLI]
- The resident will demonstrate the capability of establishing a relationship with the patients that engenders trust and will demonstrate early skill in counseling and instructing patients. [PCare, MKnow, IPComm, Prof]
- The resident will demonstrate effective communication with other health care professionals in the coordination of care of patients. [MKnow, IPComm, PracBLI]
- As the resident progresses through the first year, he or she will increasingly demonstrate that the information he or she gathers *automatically* fits into a conceptual working framework – as opposed to going through a checklist -- showing the ability to expand his or her differential diagnosis and proposed alternative treatment plans used in discussion with the clinical team. The resident will be able to articulate common complications of the diagnostic and treatment plans. [MKnow, IPComm, ProbBLI]
- The resident will demonstrate the capability of prioritizing multiple demands based on potential serious consequences with a priority ranking of: (1) important (consequential) and urgent, (2) important and less urgent, (3) urgent and less consequential, and (4) neither important nor urgent, by effectively evaluating the situation and negotiating a mutually satisfactory plan of action. [Mknow, IPComm, ProbBLI]
- The resident will show improving time management skills throughout the first year associated with the above ability to prioritize tasks. [PCare, MKnow, PracBLI]

- The resident will be able to determine when s/he does not have necessary knowledge and skills and to whom she or he can turn to in a timely manner. [PCare, MKnow, Prof, PracBLI]
- The resident will demonstrate an understanding of the capabilities and limitations of the medical inpatient and emergency department personnel. [PCare, MKnow, PracBLI]
- The resident will demonstrate the ability to monitor the course of the disease(s) of patients under their care using appropriate historical, physical, laboratory, imaging and functional findings and documenting these in the patients' charts. [PCare, MKnow, IPComm]
- In the ambulatory clinic, the resident will develop the ability to progress from gathering clinical data on the patient to generating workable assessments and plans for discussion with the supervising attending physician utilizing evidence from the literature for justifying management decisions. [PCare, MKnow, ProbBLI]
- In the ambulatory clinic, the resident will develop the ability of performing routine health maintenance services that are age and gender specific in a timely manner. [PCare, MKnow, ProbBLI]
- The resident will demonstrate early awareness of activities used to prevent adverse drug events. [PCare, MKnow, PracBLI]
- The resident will demonstrate the ability to do an electronic literature search gathering evidence for relevant clinical questions. [MKnow]

Second year:

- **By the end of the second year the resident will demonstrate that he or she is able to manage the great majority of patients semi-independently with indirect supervision or telephone consultation with attending as needed. [PCare, MKnow, IPComm]**
- At the beginning of the second year, the resident will have achieved all of the performance capabilities described under the first year. [PCare, MKnow, IPComm, Prof, PracBLI, SystBP]
- The resident will demonstrate the ability to manage an increasing number of patients by automatically performing a focused history and physical eliciting the salient features of the patient's problem and by prioritizing daily tasks. [PCare, MKnow, PracBLI]
- The resident will demonstrate the ability to lead a ward team by:
    - assessing each first year resident's and medical student's strengths and weaknesses and by filling in where needed to provide good patient care;
    - reviewing each workup by a first year resident or medical student, giving feedback for improvement, and putting the case into the perspective of what is known about the presenting problem or the specific diagnosis;
    - developing a broad differential diagnosis; and
    - providing a balanced workload so that all will get good experience and time for conferences and reading. [PCare, MKnow, IPComm, PracBLI, SystBP]
- The resident will demonstrate the ability to "run a code." [PCare, MKnow]
- The resident will demonstrate the ability to relate effectively with various people who comprise the clinical team both on-site on the specific ward where the patient is located and off-site with people who will be involved in the care of the patient, such as radiology personnel, taking into account their strengths and weaknesses. [PCare, MKnow, IPComm, Prof, PracBLI]
- The resident will demonstrate increasing skill in assessing and managing critically ill patients so that his or her interventions become more and more effective. [PCare, MKnow]
- The resident will demonstrate the ability to effectively triage patients. [PCare, MKnow, IPComm]
- In the ambulatory setting, the resident will demonstrate the ability to gather information relevant to the problems at hand and develop an assessment and plan that is reasonably congruent with the supervising attending physician's in all common and moderately common ambulatory medical problems, and be able to justify the management based on scientific evidence. [PCare, MKnow]

- In the ambulatory clinic, the resident will act in a manner showing that she or he takes individual responsibility – or "ownership" – of the patients assigned to their panel. [PCare, MKnow, Prof, PracBLI]
- In the ambulatory clinic, the resident will develop the ability to distinguish between those patients with acute problems requiring admission and those that can be followed in the ambulatory setting that is congruent with the supervising faculty physician. [PCare, MKnow]
- The resident will demonstrate the ability to conduct audits on clinical charts. [MKnow, Prof, PracBLI]
- The resident will demonstrate the ability to see an average of 5 patients per half day in the ambulatory clinic. [PCare, MKnow]
- The resident will demonstrate that she or he has provided necessary documentation for clinical management and to support the level of evaluation and management (E&M) service charged. [PCare, MKnow, PracBLI]
- By the end of the year, the resident will be able to manage referrals to consultants, formulary issues with health plans, case management issues and literature searches for important clinical questions requiring evidence-based support. [PCare, MKnow]
- The resident will demonstrate the ability to present cases at morning report and to give a brief synopsis of the disease at hand. [PCare, MKnow]
- The resident will demonstrate the ability to do a literature search on a relevant clinical question and present that in conference. [PCare, MKnow]
- The resident will demonstrate the ability to be available and capable of effectively responding to nurses' questions and concerns as well as effectively relating with a broad group of specialists in the management of the patients under their care. [PCare, MKnow, PracBLI,]
- The resident will demonstrate the ability to mentor more junior residents and medical students. [PCare, MKnow, IPComm]
- The resident will demonstrate the ability of evaluate and manage common medical emergencies. [PCare, MKnow, IPComm]

Third year:

- **By the end of the year, the resident will demonstrate the capability of performing as a competent, independent general internist and who is capable of entering subspecialty training as desired. [PCare, MKnow, IPComm, Prof, PracBLI, SystBP]**
- At the beginning of the third year, the resident will have achieved all of the performance capabilities described under the second year. [PCare, MKnow, IPComm, Prof, PracBLI, SystBP]
- The resident will demonstrate the ability to effectively triage unstable inpatients to the critical care unit, telemetry or to general medical unit. [PCare, MKnow, IPComm]
- The resident must demonstrate intermediate capability, i.e., know indications and contraindications of, and perform various procedures under direct supervision, which may include, but are not limited to: central venous catheter insertion, oral or nasal airway intubation, paracentesis, and lumbar puncture. [PCare, MKnow]
- The resident will demonstrate the ability to effectively manage a team using a fine balance of appropriate oversight and guidance individualized to each unique team. [PCare, MKnow, Prof, PracBLI]
- The resident is expected to be able to communicate effectively with patients and families and provide appropriate patient-centered care in all patient care settings. [PCare, MKnow, Prof, PracBLI]
- In the ambulatory clinic, the resident will demonstrate the ability to see 6 to 8 patients in a half-day session with increasing autonomy. [PCare, MKnow]

- The resident will demonstrate the ability to relate to patients both in addressing disease issues and illness issues, i.e., how the patient and family respond to being sick -- with caring and compassion all the while addressing the patient's expectations. [PCare, MKnow, IPComm, Prof]
- The resident will demonstrate effective communication skills with patient and families, and the multidisciplinary care team, in order to prevent or resolve conflict when needed [PCare, MKnow, IPComm, Prof]
- The resident will demonstrate effective communication skills with patients and families in sensitive situations such as domestic violence and sexually-related topics. [PCare, MKnow, IPComm, Prof]
- The resident will demonstrate the capability of evaluating and managing uncommon medical emergencies. [PCare, MKnow]
- The resident will demonstrate proficiency in mentoring more junior residents and medical students. [PCare, MKnow, Prof]
- The resident will effectively interact with all members of the team having responsibility for managing medical patients at BUMC-P and Phoenix VAMC and managing the UACOMP Internal Medicine Residency program. [IPComm, PracBLI, SystBP]
- The resident will effectively deal with appropriate people within BUMC-P and Phoenix VAMC who impact patient care or the operation of the UACOMP Internal Medicine Residency program including participating and contributing to departmental and institutional committees. [SystBP]
- The resident will demonstrate the capability of using a wide variety of available community resources. [PCare, MKnow]
- The resident will demonstrate the capability of consulting as a general internist on patients cared for by other specialties demonstrating effective professional and interpersonal communication skills. [PCare, MKnow, IPComm]
- The resident will demonstrate the ability to engage multiple resources in Banner Health System, the Veterans Affairs system, and the community to facilitate the care of the patient. [PCare, MKnow, IPComm, Prof, SystBP]
- The resident will gain understanding in appropriate utilization of resources, contribute to the successful achievement of goals set forth by the institution and residency program. [SBP, PBLI)

APPENDIX 2: INTERNAL MEDICINE MILESTONES AND TIMELINE

Greene M, et al. Charting the Road to Competence: Developmental Milestones for Internal Medicine Residency Training. Journal of Graduate Medical Education, September 2009

Competency and milestone grouping	Milestone	Timeline
A. Patient Care: Historical Data Gathering	1. Acquire accurate and relevant history from the patient in an efficiently customized, prioritized, and hypothesis driven fashion	6 months
	2. Seek and obtain appropriate, verified, and prioritized data from secondary sources (e.g. family, records, pharmacy)	9 months
	3. Obtain relevant historical subtleties that inform and prioritize both differential diagnoses and diagnostic plans, including sensitive, complicated, and detailed information that may not often be volunteered by the patient	18 months
	4. Role model gathering subtle and reliable information from the patient for junior members of the healthcare team	30 months
B. Patient Care: Performing a physical exam	1. Perform an accurate physical examination that is appropriately targeted to the patient's complaints and medical conditions. Identify pertinent abnormalities using common maneuvers	6 months
	2. Accurately track important changes in the physical examination over time in the outpatient and inpatient settings	12 months
	3. Demonstrate and teach how to elicit important physical findings for junior members of the healthcare team	24 months
	4. Routinely identify subtle or unusual physical findings that may influence clinical decision making, using advanced maneuvers where applicable	30 months
C. Patient Care: Clinical Reasoning	1. Synthesize all available data, including interview, physical examination, and preliminary laboratory data, to define each patient’s central clinical problem	12 Months
	2. Develop prioritized differential diagnoses, evidence-based diagnostic and therapeutic plan for common inpatient and ambulatory conditions	12 Months
	3. Modify differential diagnosis and care plan based upon clinical course and data as appropriate	24 months
	4. Recognize disease presentations that deviate from common patterns and that require complex decision making	36 months
D. Patient Care: Invasive procedures	1. Appropriately perform invasive procedures and provide post-procedure management for common procedures	18 months

E. Patient Care: Diagnostic tests	1. Make appropriate clinical decisions based upon the results of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids	12 months
	2. Make appropriate clinical decision based upon the results of more advanced diagnostic tests	18 months
F. Patient Care: Patient Management	1. Recognize situations with a need for urgent or emergent medical care including life threatening conditions	6 months
	2. Recognize when to seek additional guidance	6 months
	3. Provide appropriate preventive care and teach patient regarding self-care	6 months
	4. With supervision, manage patients with common clinical disorders seen in the practice of inpatient and ambulatory general internal medicine	12 months
	5. With minimal supervision, manage patients with common and complex clinical disorders seen in the practice of inpatient and ambulatory general internal medicine	12 months
	6. Initiate management and stabilize patients with emergent medical conditions	12 months
	7. Recognize situations with a need for urgent or emergent medical care including life threatening conditions	36 months
	8. Recognize when to seek additional guidance	36 months
	9. Provide appropriate preventive care and teach patient regarding self-care	36 months
	10. With supervision, manage patients with common clinical disorders seen in the practice of inpatient and ambulatory general internal medicine	36 months
	11. With minimal supervision, manage patients with common and complex clinical disorders seen in the practice of inpatient and ambulatory general internal medicine	36 months
	12. Initiate management and stabilize patients with emergent medical conditions	36 months
	13. Manage patients with conditions that require intensive care	36 months
	14. Independently manage patients with a broad spectrum of clinical disorders seen in the practice of general internal medicine	36 months
	15. Manage complex or rare medical conditions	36 months
	16. Customize care in the context of the patient's preferences and overall health	36 months
G. Patient Care: Consultative care	1. Provide specific, responsive consultation to other services	24 months

	2. Provide internal medicine consultation for patients with more complex clinical problems requiring detailed risk assessment	36 months
A. Medical Knowledge: Knowledge of core content	1. Understand the relevant pathophysiology and basic science for common medical conditions	6 months
	2. Demonstrate sufficient knowledge to diagnose and treat common conditions that require hospitalization	12 months
	3. Demonstrate sufficient knowledge to evaluate common ambulatory conditions	18 months
	4. Demonstrate sufficient knowledge to diagnose and treat undifferentiated and emergent conditions	18 months
	5. Demonstrate sufficient knowledge to provide preventive care	18 months
	6. Demonstrate sufficient knowledge to identify and treat medical conditions that require intensive care	24 months
	7. Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions	36 months
	8. Understand the relevant pathophysiology and basic science for uncommon or complex medical conditions	36 months
	9. Demonstrate sufficient knowledge of socio-behavioral sciences including but not limited to health care economics, medical ethics, and medical education	36 months
B. Medical Knowledge: Diagnostic tests	1. Understand indications for and basic interpretation of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids	12 months
	2. Understand indications for and has basic skills in interpreting more advanced diagnostic tests	18 months
	3. Understand prior probability and test performance characteristics	18 months
A. Practice Based learning and improvement: Improve the quality of care for a panel of patients	1. Appreciate the responsibility to assess and improve care collectively for a panel of patients	12 months
	2. Perform or review audit of a panel of patients using standardized, disease-specific, and evidence-based criteria	12 months
	3. Reflect on audit compared with local or national benchmarks and explore possible explanations for deficiencies, including doctor-related, system-related, and patient related factors	12 months
	4. Identify areas in resident's own practice and local system that can be changed to improve effect of the processes and outcomes of care	12 months
	5. Engage in a quality improvement intervention	36 months
B. Practice Based learning and improvement: Ask	1. Identify learning needs (clinical questions) as they emerge in patient care activities	12 months
	2. Classify and precisely articulate clinical questions	24 months

answerable questions for emerging information needs	3. Develop a system to track, pursue, and reflect on clinical questions	24 months
C. Practice Based learning and improvement: Acquires the best evidence	1. Access medical information resources to answer clinical questions and library resources to support decision making	12 months
	2. Effectively and efficiently search NLM database for original clinical research articles	24 months
	3. Effectively and efficiently search evidence-based summary medical information resources	24 months
	4. Appraise the quality of medical information resources and select among them based on the characteristics of the clinical question	36 months
D. Practice Based learning and improvement: Appraises the evidence for validity and usefulness	1. With assistance, appraise study design, conduct, and statistical analysis in clinical research papers	12 months
	2. With assistance, appraise clinical guideline recommendations for bias	12 months
	3. With assistance, appraise study design, conduct, and statistical analysis in clinical research papers	36 months
	4. Independently, appraise clinical guideline recommendations for bias and cost-benefit considerations	36 months
E. Practice Based learning and improvement: Applies the evidence to decision-making for individual patients	1. Determine if clinical evidence can be generalized to an individual patient	12 months
	2. Customize clinical evidence for an individual patient	36 months
	3. Communicate risks and benefits of alternatives to patients	36 months
	4. Integrate clinical evidence, clinical context, and patient preferences into decision-making	36 months
F. Practice Based learning and improvement: Improves via feedback	1. Respond welcomingly and productively to feedback from all members of the health care team including faculty, peer residents, students, nurses, allied health workers, patients and their advocates	12 months
	2. Actively seek feedback from all members of the health care team	12 months
	3. Calibrate self-assessment with feedback and other external data	24 months
	4. Reflect on feedback in developing plans for improvement	24 months
G. Practice Based learning and improvement: Improves via self-assessment	1. Maintain awareness of the situation in the moment, and respond to meet situational needs	24 months
	2. Reflect (in action) when surprised, applies new insights to future clinical scenarios, and reflects (on action) back on the process	36 months
H. Practice Based learning and improvement: Participates in the education of all members of the health care team	1. Actively participate in teaching conferences	12 months
	2. Integrate teaching, feedback, and evaluation with supervision of interns' and students' patient care	24 months
	3. Take a leadership role in the education of all members of the health care team.	36 months
	1. Provide timely and comprehensive verbal and written communication to patients/advocates	12 months

A. Interpersonal and Communication Skills: Communicate effectively	2. Effectively use verbal and non-verbal skills to create rapport with patients/families	12 months
	3. Use communication skills to build a therapeutic relationship	12 months
	4. Engage patients/advocates in shared decision making for uncomplicated diagnostic and therapeutic scenarios	24 months
	5. Utilize patient-centered education strategies	24 months
	6. Engage patients/advocates in shared decision making for difficult, ambiguous or controversial scenarios	36 months
	7. Appropriately counsel patients about the risks and benefits of tests and procedures highlighting cost awareness and resource allocation	36 months
	8. Role model effective communication skills in challenging situations	36 months
B. Interpersonal and Communication Skills: Intercultural sensitivity	1. Effectively use an interpreter to engage patients in the clinical setting including patient education	6 months
	2. Demonstrate sensitivity to differences in patients including but not limited to race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious beliefs	12 months
	3. Actively seek to understand patient differences and views and reflects this in respectful communication and shared decision-making with the patient and the healthcare team	30 months
C. Interpersonal and Communication Skills: Transitions of care	1. Effectively communicate with other caregivers in order to maintain appropriate continuity during transitions of care	12 months
	2. Role model and teach effective communication with next caregivers during transitions of care	24 months
D. Interpersonal and Communication Skills: Interprofessional team	1. Deliver appropriate, succinct, hypothesis-driven oral presentations	6 months
	2. Effectively communicate plan of care to all members of the health care team	12 months
	3. Engage in collaborative communication with all members of the health care team	30 months
E. Interpersonal and Communication Skills: Consultation	1. Request consultative services in an effective manner	6 months
	2. Clearly communicate the role of consultant to the patient, in support of the primary care relationship	12 months
	3. Communicate consultative recommendations to the referring team in an effective manner	36 months
F. Interpersonal and Communication Skills: Health records	1. Provide legible, accurate, complete, and timely written communication that is congruent with medical standards	6 months
	2. Ensure succinct, relevant, and patient-specific written communication	24 months
A. Professionalism: Adhere to basic ethical principles	1. Document and report clinical information truthfully	1 month
	2. Follow formal policies	1 month
	3. Accept personal errors and honestly acknowledge them	6 months

	4. Uphold ethical expectations of research and scholarly activity	36 months
B. Professionalism: Demonstrate compassion and respect to patients	1. Demonstrate empathy and compassion to all patients	3 months
	2. Demonstrate a commitment to relieve pain and suffering	3 months
	3. Provide support (physical, psychological, social and spiritual) for dying patients and their families	24 months
	4. Provide leadership for a team that respects patient dignity and autonomy	24 months
C. Professionalism: Provide timely, constructive feedback to colleagues	1. Communicate constructive feedback to other members of the health care team	12 months
	2. Recognize, respond to and report impairment in colleagues or substandard care via peer review process	18 months
D. Professionalism: Maintain accessibility	1. Respond promptly and appropriately to clinical responsibilities including but not limited to calls and pages	1 month
	2. Carry out timely interactions with colleagues, patients and their designated caregivers	6 months
E. Professionalism: Recognize conflicts of interest	1. Recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients	6 months
	2. Maintain ethical relationships with industry	30 months
	3. Recognize and manage subtler conflicts of interest	30 months
F. Professionalism: Demonstrate personal accountability	1. Dress and behave appropriately	1 month
	2. Maintain appropriate professional relationships with patients, families and staff	1 month
	3. Ensure prompt completion of clinical, administrative, and curricular tasks	6 months
	4. Recognize and address personal, psychological, and physical limitations that may affect professional performance	12 months
	5. Recognize the scope of his/her abilities and ask for supervision and assistance appropriately	12 months
	6. Serve as a professional role model for more junior colleagues (e.g., medical students, interns)	30 months
	7. Recognize the need to assist colleagues in the provision of duties	30 months
G. Professionalism: Practice individual patient advocacy	1. Recognize when it is necessary to advocate for individual patient needs	6 months
	2. Effectively advocate for individual patient needs	30 months
H. Professionalism: Comply with public health policies	1. Recognize and take responsibility for situations where public health supersedes individual health (e.g. reportable infectious diseases)	24 months
I. Professionalism: Respect the dignity, culture, beliefs, values and opinions of the patient	1. Treat patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age or socioeconomic status	1 month
	2. Recognize and manage conflict when patient values differ from their own	30 months

J. Professionalism: Confidentiality	1. Maintain patient confidentiality	1 month
	2. Educate and hold others accountable for patient confidentiality	18 months
K. Professionalism: Recognize and address disparities in health care	1. Recognize that disparities exist in health care among populations and that they may impact care of the patient	12 months
	2. Embrace physicians' role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering	36 months
	3. Advocates for appropriate allocation of limited health care resources.	36 months
A. Systems-based Practice: Works effectively within multiple health delivery systems	1. Understand unique roles and services provided by local health care delivery systems.	12 months
	2. Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, sub-acute, acute, rehabilitation, and skilled nursing.	24 months
	3. Negotiate patient-centered care among multiple care providers.	36 months
B. Systems-based Practice: Works effectively within an interprofessional team	1. Appreciate roles of a variety of health care providers, including, but not limited to, consultants, therapists, nurses, home care workers, pharmacists, and social workers.	6 months
	2. Work effectively as a member within the interprofessional team to ensure safe patient care.	6 months
	3. Consider alternative solutions provided by other teammates	12 months
	4. Demonstrate how to manage the team by utilizing the skills and coordinating the activities of interprofessional team members.	36 months
C. Systems-based Practice: Recognizes system error and advocates for system improvement	1. Recognize health system forces that increase the risk for error including barriers to optimal patient care	12 months
	2. Identify, reflect upon, and learn from critical incidents such as near misses and preventable medical errors	12 months
	3. Dialogue with care team members to identify risk for and prevention of medical error	24 months
	4. Understand mechanisms for analysis and correction of systems errors	24 months
	5. Demonstrate ability to understand and engage in a system level quality improvement intervention.	36 months
	6. Partner with other healthcare professionals to identify, propose improvement opportunities within the system.	36 months
D. Systems-based Practice: Identifies forces that impact the cost of health care and advocates for cost-effective care	1. Reflect awareness of common socio-economic barriers that impact patient care.	12 months
	2. Understand how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines)	12 months
	3. Identify the role of various health care stakeholders including providers, suppliers, financiers, purchasers and consumers and their varied impact on the cost of and access to health care.	24 months

	4. Understand coding and reimbursement principles.	24 months
E. Systems-based Practice: Practices cost-effective care	1. Identify costs for common diagnostic or therapeutic tests.	6 Months
	2. Minimize unnecessary care including tests, procedures, therapies and ambulatory or hospital encounters	6 Months
	3. Demonstrate the incorporation of cost-awareness principles into standard clinical judgments and decision-making	18 Months
	4. Demonstrate the incorporation of cost-awareness principles into complex clinical scenarios	18 Months

APPENDIX 3: PROFESSIONALISM POLICY (revised June 2019)

Our program depends on every resident reliably being present for patient care duties and completing tasks as assigned. When these expectations are not met, it places a significant burden on others, contributes to a perception of not being committed to the profession and creates an environment that is not conducive to all members of our team being able to work in a respectful environment. These offenses have been designated as violations of the professionalism policy in two distinct categories- Professional Conduct and Professional Accountability. General examples are provided in the description below.

Repeated offenses or lack of demonstrated commitment to improvement will be included in future letters of reference and milestone evaluations.

Professional Conduct: Violations of professional conduct include but are not limited to instances of an unexcused absence (see above), failure to return a call within 30 minutes when on back-up, dishonesty with colleagues, inappropriate use of sick call, unprofessional interactions with colleagues, members of the healthcare team or students, and equivalent behavior.

- 1st offense: Warning
- 2nd offense: Assigned one extra weekend of back-up call
- 3rd offense: Assigned one extra week of back-up call without the ability to earn FLEX days for time called in.
- 4th offense: Letter of concern from the CCC with requirement that resident creates a written action plan and schedule a meeting with their APD advisor within 7 days .
- 5th offense- Clinical Competency Committee to consider disciplinary action as outlined in the UA COMP Graduate Medical Education Manual.

Professional Accountability: Violations of professional accountability include but are not limited to inadequate attendance at conferences, excessive tardiness, excessive delays in completing administrative tasks (medical records, compliance modules, MKSAP, clinic in-box, etc.) and failure to respond to pages on days that resident is assigned to work.

- 1st offense: Warning
- 2nd offense: No routine schedule requests granted until issues resolved.
- 3rd offense: Written action plan and explanation to APD advisor and no routine schedule requests or FLEX day use granted until until issues resolved.
- 4th offense: Formal Letter of Concern from the Clinical Competency Committee and no routine schedule requests or FLEX day use granted until until issues resolved.
- 5th offense: Clinical Competency Committee to consider disciplinary action as outlined in the UA COMP Graduate Medical Education Manual and no routine schedule requests granted until the issue is resolved.

APPENDIX 4: SUMMARY OF PROCEDURE INDICATIONS, COMPLICATIONS, AND CONTRAINDICATIONS (updated 9/2016)

Abdominal paracentesis
Indications: determine etiology of ascites, relieve intrabdominal pressure
Complications: perforation of intraabdominal viscus, bleeding, infection, splenic/hepatic laceration, hypotension (if large volume is removed), acute kidney injury (if large volume is removed)
Contraindications: Acute abdomen, infection at entry site, pregnancy, significant bleeding diathesis (relative contraindication), prerenal azotemia (large volume paracentesis relatively contraindicated), hemodynamic instability (large volume paracentesis relatively contraindicated)

Arterial puncture
Indications: analysis of ABG, emergency blood sample when venous access is unavailable
Complications: hemorrhage, thrombosis, nerve damage, infection, distal limb ischemia
Contraindications: inability to palpate pulse, inadequate collateral blood flow, infection at entry site

Arthrocentesis
Indications: relieve pressure, obtain diagnostic fluid, injection of medication
Complications: hemorrhage, nerve damage, infection
Contraindications: infection at entry site

Central venous line placement
Indications: venous access, monitor central venous pressure, hemodialysis, Swan-Ganz, pacemaker placement
Complications: pneumothorax, hemorrhage, infection, air embolus, AV fistula, pericardial tamponade, nerve damage, SVC obstruction; cardiac dysrhythmias, airway compromise
Contraindications: infection/burn at entry site, distortion of local anatomy, significant bleeding diathesis (relative contraindication)

Lumbar puncture
Indications: evaluate for meningeal infection, inflammation or malignancy; evaluate for subarachnoid hemorrhage when imaging is equivocal
Complications: headache, spinal hematoma, brain herniation, back pain, meningitis, bleeding, infection
Contraindications: infection at entry site, raised intracranial pressure, significant bleeding diathesis, intracranial mass

Nasogastric intubation
Indications: aspirate stomach to assess for bleeding or remove ingested toxins, relieve GI obstruction, administer medications or feedings
Complications: epistaxis, aspiration, pneumothorax, bleeding, perforation of esophagus, tissue necrosis, sinusitis
Contraindications: facial or basilar skull fracture, esophageal stricture, caustic ingestion, recent oropharyngeal/nasal/gastric surgery, Zencker's diverticulum, penetrating cervical wounds, unsafe/unprotected airway

Thoracentesis
Indications: evaluate etiology of pleural effusion, improve ventilation in cases of large effusion

Complications: pneumothorax, bleeding, infection, laceration of liver/spleen/diaphragm, pulmonary edema (when larger volumes removed), hypoxia
Contraindications: infection at entry site, significant bleeding diathesis

Endotracheal intubation
Indications: Respiratory failure, protect airway
Complications: Hypoxia, esophageal intubation, aspiration, vocal cord injury
Contraindications: upper airway obstruction, mandibular fracture
Residents should not intubate any patient without attending supervision except in emergencies

Skin biopsy
Indications: evaluate etiology of abnormal skin lesion
Complications: infection, bleeding, nerve injury, cosmetic defect
Contraindications: infection at biopsy site

Cryosurgical removal of skin lesions
Indications: removal of benign or pre-malignant skin lesions
Complications: cosmetic defect, infection, bleeding, neuropathy, swelling, ulcer
Contraindications: hypersensitivity, possibly malignant lesion, poor wound healing, infection at site

Arterial line placement
Indications: continuous precise blood pressure monitoring, frequent blood gas analysis
Complications: thrombosis, embolism, ischemia, bleeding, infection, aneurysm, nerve damage
Contraindications: inadequate collateral blood flow, severe arterial disease, infection at entry site, inability to palpate pulse

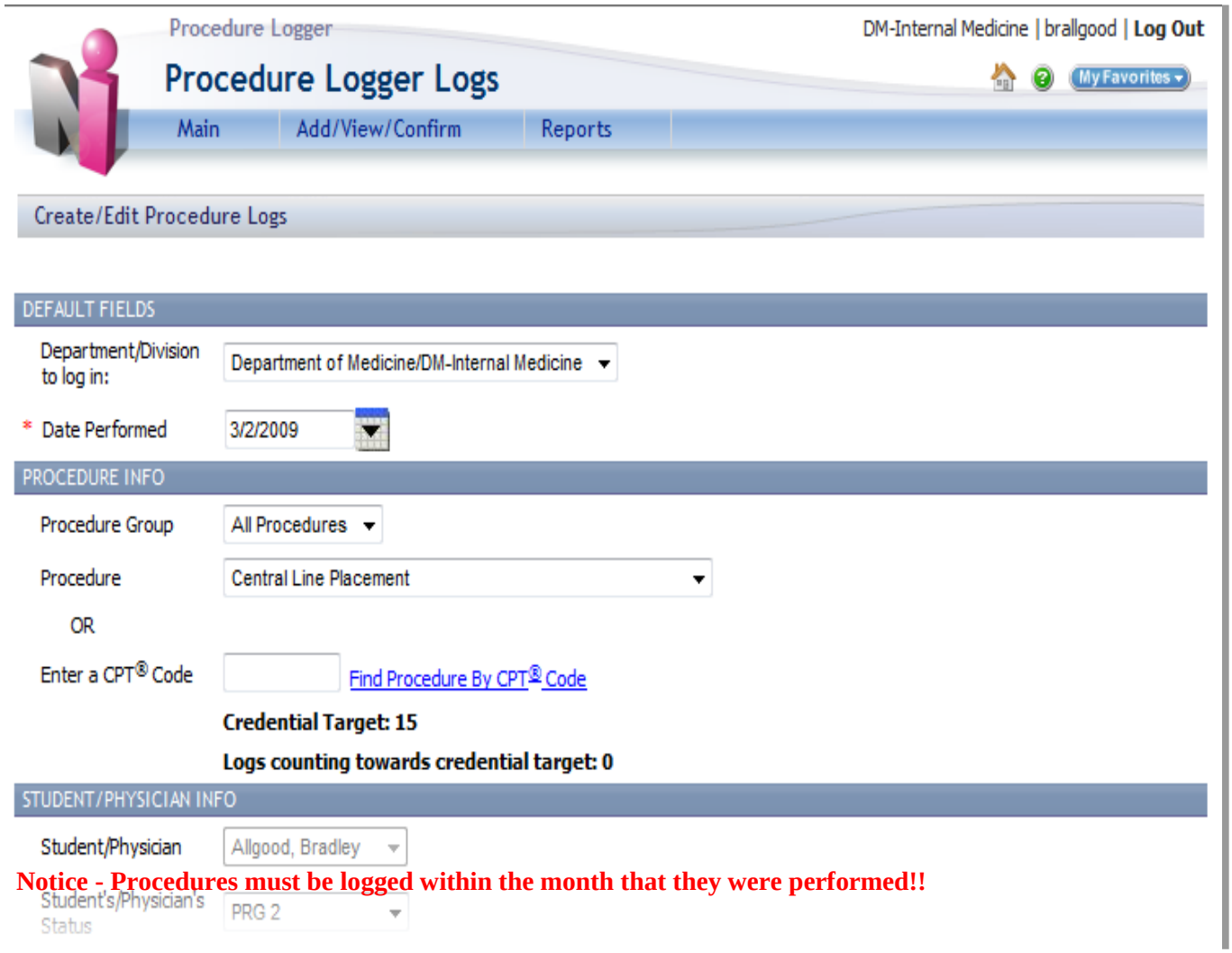
Treadmill exercise testing
Indications: assess CAD risk, assess functional capacity
Complications: CHF, arrhythmia, hypotension, acute MI, syncope, CVA
Contraindications: very recent acute MI, unstable angina, decompensated CHF, hemodynamically significant aortic stenosis, bundle branch block, inability to walk safely

*Relative contraindications are conditions in which the procedure should be performed only in urgent circumstances, by the most qualified staff

APPENDIX 5: HOW TO LOG PROCEDURES INTO NEW INNOVATIONS

Website: www.new-innovations.com/login
Institution: GSRMC (all caps)
Username: jsmith (first initial, whole last name)
Password: jsmith (same as username)
Logging Procedures:

1. Select Main > Procedure Logger then choose Add/View/Confirm > Add
2. Complete Procedure form and click Save
   To log multiple procedures on the same patient, click Save and Retain



Notice - Procedures must be logged within the month that they were performed!!

If you have problems logging into the system please contact Jane Sanborn 602-839-2922 or *jane.sanborn@bannerhealth.com*

APPENDIX 6: BOARD PREPARATION DETAILS:

Non-Call Month MKSAP requirements:

Rotation:	**MKSAP Section**
Ambulatory	Johns Hopkins Modules as assigned
Anesthesia	Pulmonary and Critical Care Medicine
Allergy	AHD topic of the month
Cards-BU	Cardiovascular Medicine
Cards-OP	Cardiovascular Medicine
Cards-OP (VA)	Cardiovascular Medicine
Cards-OP (VA)	Cardiovascular Medicine
Consult-VA	Cardiovascular Medicine
Derm	Dermatology
Derm-VA	Dermatology
Endo-VA	Endocrinology and Metabolism
ED	General Internal Medicine
Endo-BU	Endocrinology and Metabolism
GI-BU	Gastroenterology and Hepatology
GI-VA	Gastroenterology and Hepatology
Geri-BU	General Internal Medicine
Geri-Boswell	General Internal Medicine
Hem.Onc-VA	Hematology and Oncology
Hem. Onc-Anderson	Hematology and Oncology
Hepatology	Gastroenterology and Hepatology
Hepatology-BU	Gastroenterology and Hepatology
Hospitalist	None
Interventional Rad	AHD topic of the month
ID-BU	Infectious Disease
ID-VA	Infectious Disease
Nephro-Dhal	Nephrology
Nephro-SKI	Nephrology
Nephro-VA	Nephrology
Neurology	Neurology
OMFS	AHD topic of the month
Optho	AHD topic of the month
Palliative-VA	AHD topic of the month
Palliative-BU	AHD topic of the month
PM&R-VA	AHD topic of the month

Pulm-IP	Pulmonary and Critical Care Medicine
Pulm-OP VA	Pulmonary and Critical Care Medicine
Pulm-OP BU	Pulmonary and Critical Care Medicine
Pulm-Saggar	Pulmonary and Critical Care Medicine
Radiology-BU	AHD topic of the month
Rad.Onc-BU	AHD topic of the month
Research	AHD topic of the month
Rheum-Private	AHD topic of the month
Rheum-VA	AHD topic of the month
Sports Med	AHD topic of the month
Tox	AHD topic of the month
UC-Cigna	AHD topic of the month
Wesley Clinic	AHD topic of the month
Women's Health	AHD topic of the month

AHD topics of the month
July-Hospital Medicine/General IM
August- Infectious Disease
September- Hematology (MKSAP -Hematology/Oncology)
October- Pulmonary
November- GI/hepatology
December: Neurology;
January: Nephrology
February: Oncology (MKSAP -Hematology/Oncology)
March: Rheumatology
April: Endocrinology
May: Cardiology
June: Practice Board Exam

AHD objectives sample: Here is a sample from a resident who used this requirement to lead to significant improvement in ITE results the following year.

Lymphoma

Initial workup for lymphoma:
Detailed history including travel history, insect bites comma sexual history, injection drug use, blood product transfusions, new medications comma fever night sweats or weight loss.
Physical examination determining the site of lymphadenopathy the size and consistency.
For their assessment of the lymph node when suspecting a lymphoma with chest radiograph complete blood count with differential and a serum chemistry panel.

Type of biopsy in lymphoma: Excisional biopsy is done to preserve the lymph node architecture. Cord needle biopsy can be used for deep lymph nodes but fine needle aspiration should be avoided.

Test performed on the lymph node in addition to histopathology are:
Cytogenetic analysis, FISH,
Immunophenotypic analysis and Gene expression profiling

Blood work when suspecting lymphoma: CBC + diff, ESR, CMP, urate, LDH, B2microglobulin, immunoglobulins.
Screening for viral infections hepatitis B and C, HIV, HHV 8, HTLV1,H pylori, EBV

After the lymphoma is diagnosis PET/ CT scan and an iliac crest bone marrow biopsy is done to complete staging.

ITE missed objectives Sample:

-From your individual score report:

Cardiology

Diagnose cardiac tamponade.
Diagnose constrictive pericarditis.
Diagnose myocarditis.
Diagnose sinus tachycardia.
Identify high-risk patients requiring coronary angiography.
Manage atrioventricular nodal block after an acute inferior myocardial infarction.**
Manage bleeding risk before colonoscopy in a patient taking antiplatelet therapy.
Manage ischemic heart disease treated with a stent.**
Manage isolated symptomatic premature ventricular contractions.
Manage Mobitz I second-degree heart block.**
Manage noncardiac chest pain.**
Perform cardiac testing in a patient with a cardiac pacemaker and an intermediate pretest probability.
Prevent sudden cardiac death.
Treat a patient with heart failure and a reduced ejection fraction.
Treat atrial fibrillation.

Endocrinology

Diagnose Cushing syndrome.
Diagnose diabetes mellitus.
Diagnose pheochromocytoma.
Manage a lipid abnormality in a patient with diabetes mellitus.
Manage primary adrenal insufficiency.

Then look up the topics in MKSAP or other source to study the content

Diagnose cardiac tamponade.	Cardiac tamponade should be suspected when there is a compatible history, hypotension, and an elevated jugular venous pressure and pulsus paradoxus. An enlarged cardiac silhouette may be seen on chest radiograph ("water-bottle heart"). The ECG typically demonstrates sinus tachycardia and electrical alternans. Signs of cardiac tamponade include diastolic collapse of the right atrium and right ventricle, ventricular septal shifting with respiration, and enlargement of the inferior vena cava. With Doppler echocardiography, respiratory variation in mitral inflow can be detected early in the evolution of tamponade. Moreover, the changes in mitral inflow are highly sensitive, and may precede changes in cardiac output, blood pressure, and other echocardiographic evidence of tamponade.

Appendix 7: ROTATION SELECTION GUIDE FOR UA COM-P IM RESIDENTS

We have many incredible offerings for our electives and rotations in addition to the mandatory electives you will be assigned automatically. You can use your career interests to guide your schedule selection. If you are undecided, you will select a mix.

The program leadership will review your requested rotations with those recommended for your career goals, your individual ITE scores and the ABIM/ACGME requirements.

Ambulatory IM

The following are recommendations as per PGY levels in addition to the required general internal medicine ambulatory month, which will be assigned automatically.

	PGY1	PGY2	PGY3
Other Ambulatory	• Ambulatory Private Practice • Wesley FQHC • Adelante FQHC • VA Community Based outpatient clinic (CBOC)	• Wesley • Adelante Health Care • St. Vincent de Paul • VA Community Based outpatient clinic (CBOC)	• Private practice • Cigna Urgent care • Business of Medicine

Other recommended electives:

- Cardiology Outpatient
- Outpatient Neurology – in development
- Endocrine (BUMCP/VA)
- Dermatology
- Allergy/ Immunology
- Pain and Addiction
- Heme/onc
- VA Rheumatology + PMR
- VA Pulmonary
- Palliative care
- Women's Health*
- Sports Medicine

Hospital Medicine:

- Hospital Medicine - BUMCP
- Inpatient Pulmonology - BUMCP

- GI – VA
- Endocrinology
- Infectious Disease - VA or BUMCP
- Nephrology
- Palliative Care - VA and BUMCP
- Heme/Onc - Banner MD Anderson

Subspecialty Fellowship

You can choose up to 3 electives in a particular sub-specialty of your choice but it must be assured that you will have completed all of the program requirements and have diverse experiences with the different recommended electives.

- Cardiology:
    1. Academic Cardiology Service (PGY1 or PGY2)
    2. VA cardiology (PGY1 or PGY2)
    3. Outpatient or Community Cardiology or other rotation with mentor

    Recommended electives- toxicology, palliative, rheumatology, research 1

- Endocrinology
    1. Endocrinology: it is a basic combination of Banner and the VA
    2. Advanced Endocrine: Customized rotation to focus on your areas of interest

    Recommended electives- toxicology, palliative, rheumatology, research 1

- Gastroenterology:
    1. VA GI
    2. Banner GI (inpatient and outpatient)
    3. Another rotation in 1 or 2 based on your specific interest

    Recommended electives- allergy/immunology, palliative, research 1

- Heme/onc:
    1. Banner MD Anderson General Heme/Onc: For your first rotation, you will rotate through a variety of clinics to gain exposure to a variety of mentors and areas of focus. You will be allowed to make some specific selections based on your interests
    2. Banner MD Anderson Advanced Heme/Onc
    3. Away Heme/onc (coordinate to select a program that you are interested in)

    Recommended electives- palliative, ID, dermatology, GI, Pulm, research 1

- Infectious disease:
    1. ID BUMCP
    2. VA ID
    3. Away or Advanced ID at BUMCP or VA

    Recommended electives- Heme/onc, rheumatology, allergy/immunology, pulmonology, research 1, dermatology, radiology

- Nephrology:
    1. VA Nephrology
    2. AKDHC (Dr. Dahl) BUMCP
    3. Transplant Nephrology- Dr. Khurana (just sign up for Nephrology-SKI and then we will indicate a desire for transplant)

Recommended electives- palliative, rheumatology

- Pulm/CC:
    1. General Pulm B-UMCP or VA
    2. Advanced Lung Disease B-UMCP
    3. Based on interest/research

    Recommended electives- toxicology, palliative, allergy/immunology, rheumatology, ID, research

- Rheumatology:
    1. VA Rheumatology/PM&R
    2. BUMCP Rheumatology with Dr. Smith (needs special arrangement)
    3. Sports Medicine

    Recommended electives- allergy/immunology, heme/onc, ID, dermatology, nephrology

Areas of Residency Focus:

- Service and Community Health-
    1. Wesley
    2. St. Vincent de Paul
    3. Adelante (any year)
- Global Health:
    1. Wesley, St. Vincent de Paul or Adelante
    2. away/international rotation (PGY3)
- Teaching:
    1. Educational Leadership Rotation (new in 2019*)

Appendix 8: BUMCP IM RESIDENCY LIST OF ELECTIVES 2019-2020

Rotation Name	Brief Description
Allergy and Immunology – VA	Inpatient and outpatient
Allergy and Immunology – Private Outpatient Practice	Office setting, adult and pediatric patients
Ambulatory – BUMCP IMC (*this is a required rotation for PGY1 and 2 categorical IM residents with IMC continuity clinic but may also be taken as an elective)	Focuses on general IM, with exposure to subspecialty outpatient practices and unique opportunities with underserved populations
Ambulatory – VA (same as Ambulatory BUMCP IMC)	Exposure to outpatient VA system and selected specialties
Ambulatory: Cigna Urgent Care	Ambulatory Selective that can be taken at any time
Ambulatory: Wesley Center FQHC	Patient population – low income, un- and underinsured
Ambulatory: Adelante FQHC	Patient population – low income, un- and underinsured
Ambulatory: St. Vincent de Paul	Free clinic
Ambulatory: Private Practice	Helpful for those interested in private practice primary care
Ambulatory: VA Community Based Outpatient Center	Exposure to outpatient VA system and selected specialties
Ambulatory: Business of Medicine	A behind-the-scenes look at the business side of health care
Anesthesiology – BUMCP	Working directly with anesthesiology faculty to improve procedural skills and enhance knowledge in cardiopulmonary physiology. Requires PD approval as it is a non-IM specialty and there are ABIM limits.
Cardiology – Academic Cardiology Service BUMCP	Option for core cardiology rotation – work directly with fellow and attending on busy inpatient cardiology consult service
Cardiology – BUMCP	Option for core cardiology rotation – work directly with private practice cardiology attending
Cardiology – VA	Option for core cardiology rotation – work directly with fellow and attending
Cardiology – Outpatient BUMCP	Option for core cardiology experience with exposure to subspecialized outpatient cardiology clinics including preventive, women's, structural, EP, and more
Clinical Informatics	Work with the Clinical Informatics program director and fellows understanding this specialty and participating in projects.

Dermatology – BUMCP	Medical dermatology with skin manifestations of systemic diseases, inpatient and outpatient consults and excellent teachers
Dermatology – VA Outpatient	General dermatology in a clinic that now also has a derm residency and so is used to teaching.
Educational Leadership	For residents interested in medical education, this customized experience provides opportunities with leaders in med ed to advance skills
Endocrinology – (combination of BUMCP & VA)	VA component – combination of inpatient and outpatient BUMCP component – inpatient consults
GI – BUMCP	Advanced GI experience – 2 weeks inpatient consults, 2 weeks specialized outpatient GI clinics including general GI, esophageal, general hepatology
GI – VA	Recommended as core GI rotation, good foundation in general inpatient and outpatient GI
Geriatrics – combo VA and BUMCP	VA component - mostly outpatient experience BUMCP component – mostly inpatient, exposure to current trends: ACE unit, rehab, co-management
Geriatrics – Banner Boswell Hospital	Far away but worth it – highly regarded rotation, mostly outpatient with geriatricians and community resources
Hematology/Oncology – VA	General heme/onc with the VA population. Large number of lung, GI cancers.
Hematology/Oncology – Banner MD Anderson Cancer Center Mesa	Rotate with heme/onc specialists in focused areas (you get to choose). Diverse patients and faculty in a cancer center with comprehensive care.
Hospitalist - BUMCP	Direct patient care with an academic hospitalist in all areas of hospital medicine not commonly seen on general ward rotations, including Neuro ICU, Orthopaedics, Observation, Rehab, and others.
Hospitalist- other	If you are considering being a hospitalist at another Banner hospital, this rotation can be done at another hospital
ID – BUMCP	Gain knowledge and confidence in the work up and treatment of common complaints and infections, appropriate antimicrobial stewardship, appropriate antibiotic choice/duration
ID – VA	Seniors only. As above, same objectives
Nephrology – Southwest Kidney Institute (BUMCP)	Work with Drs. Khurana, Yee, Go and their group, includes specific exposure to transplant nephrology. Inpatient and outpatient

Nephrology – Arizona Kidney Disease and Hypertension Center (BUMCP)	With Dr. Dahl and Zaharia. Inpatient and outpatient
Nephrology – VA	Inpatient and outpatient
Neurology- Outpatient	This is in development but will include experiences in all of the outpatient neurology clinics
Pain and Addiction: BUMCP/VA	Combination of the VA chronic pain and wellness center, the BUMCP addiction medicine clinic and inpatient consults
Palliative Care – BUMCP/VA	Management of symptoms associated with advanced chronic illness, gain experience and comfort in end-of-life and goals-of-care discussions.
Psychiatry	Outpatient, may also include time with collaborative care team. Requires PD approval as it is a non-IM specialty and there are ABIM limits.
Pulmonology, Inpatient – BUMCP	Combination of general pulm, ALD and inpatient procedures. Management of ILD, Pulmonary HTN, severe/refractory COPD exacerbations, complicated & unusual pulmonary infections, etc.
Pulmonology – VA	Outpatient focus with some inpatient
Pulmonary-ALD	Advanced pulmonary elective for those committed to pulm/cc fellowship. Will include some exposure to pulm procedure service and ALD.
Radiation Oncology – BUMCP	Only for those residents pursuing oncology. Requires PD approval as it is a non-IM specialty and there are ABIM limits.
Radiology – BUMCP	Focus on fundamentals in x ray, CT, MRI. Requires PD approval as it is a non-IM specialty and there are ABIM limits.
Clinical research 1	Foundations of clinical research, although the rotation can be scheduled without approval, starting requires completion of pre-requisites (CITI training, project proposal) approved by research faculty.
Clinical research 2	Advanced clinical research, requires completion of Research 1 and approval by research faculty.
Research – Basic Science	Foundations of basic science research, most likely in UACOMP pulmonary vascular lab but can be established elsewhere if resident has particular experience, mentorship or particular interest.
Rheumatology and PM&R – VA	Combination of rheumatology and interventions with PM&R
Sports Medicine – BUMCP Outpatient	Work with Dr. Erickson and Dr. Werk with medical sports medicine (nonsurgical)

Toxicology – BUMCP	Inpatient consults, poison center, few call nights, Friday morning conferences, excellent teaching
Women's Health/Gyn	This is under development and will be a combination of community, BUMCP and VA. If you are interested, please indicate and we will work to accommodate a schedule.
Away – Global Health	Independent, resident identifies preceptor with the help of the Director of Global Health UA COMP. Can be scheduled without approval, starting requires completion of pre-requisite paperwork and approval by PD.
Away – Subspecialty	Independent, resident identifies preceptor. Can be scheduled without approval, starting requires completion of pre-requisite paperwork and approval by PD.