

**Policies for the Internal Medicine Residency Training Program**  
**University of Arkansas for Medical Sciences**  
**July 1, 2016 to June 30, 2017**

The residency program is designed to provide residents with an extensive experience in the art and science of medicine in order to achieve excellence in the diagnosis, care, and treatment of patients. To achieve this goal, residents agree to abide by certain policies and guidelines. In return, they are given a number of benefits and the training they need to be successful in their careers. The residency program follows all UAMS College of Medicine Graduate Medical Education Committee (GMEC) policies, which are found at <http://medicine.uams.edu/current-residents/gme-committee-policies/>.

Below is a look at the policies and fair process procedures of the residency program.

<b>Policy: <i>Eligibility, Selection, and Appointment</i></b>
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In accordance with the GMEC policy on Recruitment and Appointment, the following describes the eligibility, application, selection processes, and procedure for appointment to the Internal Medicine training program.

The Internal Medicine residency program uses both objective and subjective criteria to select applicants. The selection and appointment of residents to the Internal Medicine program are the responsibility of the Chairman, Dr. James Marsh and the Program Director, Dr. Michael Saccente. The application process meets all requirements of the Equal Employment Opportunity Act and the Americans with Disability Act and does not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status. The criteria and processes for resident selection follow:

*Application Process*

The UAMS Department of Internal Medicine participates in the Electronic Residency Application System (ERAS), developed by the Association of American Medical Colleges (no paper applications), for the Categorical Internal Medicine Training Program (Quota 20). Applicants must be registered with the National Resident Matching Program (NRMP). Applicants should contact the residency coordinator, Sheila Rupley, at the following e-mail address: [imresident@uams.edu](mailto:imresident@uams.edu) for questions regarding specific requirements.

The required documents for the application process are:

- Completed and certified ERAS common application form
- Personal Statement
- Curriculum Vitae
- Medical school transcript for all medical schools attended
- Letter from the Dean of the medical school attesting to the applicant's good standing

- Three-letters of recommendation from faculty and/or preceptors who are knowledgeable of the applicant's clinical skills
- Letters from prior residency programs where applicable
- Current ECFMG certification
- Proof of citizenship or immigration status
- Certified USMLE or COMLEX transcripts

When received, these materials will be reviewed by the Program Director and Associate Program Directors, and interviews will be scheduled at their discretion. Applicants will be informed about interview decisions via email.

### Eligibility

As Program Director, Dr. Michael Saccente, is responsible for verifying that an applicant is eligible for appointment and meets the following eligibility requirements:

- An applicant must be able to carry out the duties as required by the Internal Medicine residency program
- An applicant must demonstrate the following English language proficiency to the satisfaction of the Program Director:
  - Proficiency in reading and writing printed English
  - Proficiency in understanding spoken English on conversational and medical topics
  - Proficiency in speaking English on conversational and medical topics

Any appointed resident found to be in violation of the English proficiency eligibility requirements will be referred, at the expense of the program, for appropriate remediation.
- An applicant must meet one of the following qualifications as established by the ACGME:
  - A graduate of a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME)
  - A graduate of a college of osteopathic medicine in the United States or Canada accredited by the American Osteopathic Association (AOA)
  - A graduate of a medical school outside the United States who has completed a Fifth Pathway program provided by an LCME-accredited medical school
  - A graduate who holds a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction
  - A graduate of a medical school outside the United States or Canada with one of the following qualifications:
    - A currently valid certificate from the Education Committee for Foreign Medical Graduates, or
    - A full and unrestricted license to practice medicine in a U.S. licensing jurisdiction

- An applicant is eligible for appointment only after a negative result on a pre-employment drug test administered by the UAMS Drug Testing Program (UAMS Administrative Guide Policy 3.1.14).
- All appointments are contingent upon successful completion of a criminal background check (GMEC Policy 1.200.IV). At the time of interview, he/she will complete a self-disclosure form listing all convictions, guilty pleas, pleas of no contest (or nolo contendere) to any felony, misdemeanor or any offense other than a minor traffic violation. Candidates are encouraged to confidentially discuss, with the Dr. Saccente prior to acceptance of an interview, any issues that might prevent appointment.
- An applicant must meet all program-specific eligibility requirements. These may include, but are not limited to, the following:
  - Application only submitted through the Electronic Resident Application System (ERAS) and participation in the National Resident Matching Program (NRMP)
  - Not more than 7 years of time elapsed since completion of medical school training or the practice of medicine as a physician
  - Successful completion of any step of the USMLE or COMLEX in no more than 3 attempts per step (ASMB Regulations 3 & 14)
  - Since pursuing a career in Arkansas is desired, the program shall not admit a resident whom the Arkansas State Medical Board (ASMB) will not consider for an Arkansas license. See Arkansas Medical Practices Act 17-95-401 through 17-95-407 on Licensing, Regulations 3 & 14 of the Regulations of the Arkansas State Medical Board. An educational license is not sufficient to meet this eligibility requirement (GMEC Policy 1.2.00.IIA)
  - The ability to reside continuously in the U.S. for the length of training
  - A commitment to complete the entire residency program
  - A commitment to taking and passing the American Board of Internal Medicine Certifying Exam

### Selection

Applications are downloaded from ERAS on a daily basis and reviewed for completion and eligibility by Dr. Saccente and/or Associate Program Directors. The following information must be received before the application will be considered and before an applicant is invited to an interview: common application form, Dean's letter, medical school transcript, USMLE or COMLEX transcript, personal statement, and minimum of three letters of recommendation.

Once an applicant has been found to meet minimal selection criteria, the program coordinator contacts him/her by e-mail to schedule an interview. An applicant invited for an interview will receive in writing and/or will sign an attestation that he/she has seen the terms, conditions and benefits of appointment (and employment) including financial support, vacation, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the resident and their family, and conditions under which living quarters,

meals and laundry or the equivalents are provided. Applicants can access this information through the UAMS Resident Handbook at [www.uams.edu/gme/toc.htm](http://www.uams.edu/gme/toc.htm). Applicants also complete a self-disclosure form listing all convictions, guilty pleas, and pleas of no contest (nolo contendere) to any felony, misdemeanor or any offense other than a minor traffic violation. This form is signed and returned to Ms. Rupley by the date the interview is conducted.

Applicants will receive a list of recommended hotels in Little Rock. An informal dinner with 3-4 residents is scheduled the evening prior to the interview day. The interview consists of a full day beginning with an introduction and welcome from Dr. Saccente or an Associate Program Director, followed by a presentation by the Chief Residents. The rest of the day consists of a one-on-one interview with a faculty member, a tour of the University Hospital and the VA Hospital, catered lunch with at least 4-6 residents, attendance at Afternoon Case Discussion, a tour of Little Rock, and exit interviews conducted by Dr. Saccente.

Faculty from the Department of Internal Medicine perform interviews and submit written evaluations that are included with the application. Current house staff will meet informally with each applicant during the interview process and will help determine suitability for ranking through a house staff committee meeting.

Criteria used for selection may include, but are not limited to, the following:

- Review and confirmation of eligibility requirements
- Verbal and written communication skills (personal statement and interviews)
- Honesty, integrity, and reliability
- Work ethic
- Maturity and emotional stability
- Volunteerism during college and medical school
- Extra-curricular activities in college and medical school, including leadership roles
- Overall academic performance in medical school
- Medical school transcript
- Letters of recommendation from faculty
- Dean's letter
- Demonstrated ability to choose goals and to complete the tasks necessary to achieve those goals
- Motivation to pursue a career in the specialty of Internal Medicine
- Prior research and publication experience
- Recent clinical training or experience
- Performance on standardized medical knowledge tests
- Lack of history of drug or alcohol abuse
- The ability to reside continuously in the U.S. for the length of training

Following the interview, the Program Selection Committee, composed of Dr. Saccente, Associate Program Directors, Chief Residents, residents, and Ms. Rupley reviews the applicant's file and written interview evaluations and ranks the applicant based on the criteria above.

After discussion by the Program Selection Committee, Dr. Saccente compiles a final list for submission to the NRMP. Dr. Marsh confirms the final rank list.

### Appointment/Registration

Upon verification by Dr. Saccente that an applicant has met eligibility requirements, completed the application process, and been selected according to established criteria, the applicant will begin the process of appointment and registration with the UAMS College of Medicine. An applicant is considered fully appointed and registered **only after all** of the following documents have been completed and returned to the Assistant Dean for House Staff Affairs (Dwana McKay). Once Ms. McKay has received all the documents, the applicant is registered in the payroll system to receive a stipend and may begin the residency program.

- Documentation of a negative drug test
- Successful completion of a criminal background check
- Verification of successful graduation if previously anticipated. For graduates of US or Canadian medical schools this includes a final official transcript, or letter from the Registrar, or a notarized copy of the diploma. For graduates of medical schools outside the US and Canada, this includes a currently valid ECFMG certificate.
- All of the following forms (with valid signature):
  - Resident Agreement of Appointment (contract)
  - Medical Records Agreement
  - Attestation acknowledging receipt of GMEC policies/procedures and Terms and Conditions of Appointment, and Benefits
  - Confidential Practitioner Health Questionnaire
  - Employee Drug Free Awareness Statement
  - House Staff Medical Screening Form
  - Postdoctoral Medical Education Biographical Data Form
  - Long Term Disability Form
  - I-9, State & Federal Tax Forms
  - Direct Deposit Authorization Form
- Copy of a valid visa (if applicable)
- Incoming residents are expected to attend Orientation/Registration in mid-June

<b>Policy: <i>Reappointment, Evaluation, Promotion, and Disciplinary Actions</i></b>
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### Reappointment and Promotion/Graduation

Educational appointments to the Internal Medicine residency program are for a term not exceeding one year. The Resident Agreement of Appointment, which outlines the general responsibilities for the UAMS College of Medicine and for the resident, is signed at the beginning of each term of appointment. Renewal of the Resident Agreement of

Appointment for an additional term of education and promotion to the next level of training is dependent upon the resident performing at an acceptable level. The Clinical Competency Committee (see below), with guidance from Dr. Saccente and Dr. Marsh, make decisions regarding reappointment, promotion/graduation, and disciplinary actions.

The Internal Medicine program strives to develop physicians who are clinically competent in the field of Internal Medicine. Physicians completing the Internal Medicine program will be eligible for certification by the American Board of Internal Medicine with an ultimate goal of a 100% pass rate on the certification examination.

Clinical competence requires:

1. Patient Care: Gather essential, accurate patient information; order appropriate tests; make accurate diagnoses; perform competently; counsel patients and families; prescribe appropriate medication and treatment.
2. Interpersonal and Communication Skills: Document pertinent information clearly; listen actively; use effective nonverbal behaviors; work effectively as member of a team.
3. Medical Knowledge: Know and apply basic sciences; demonstrate analytical approach to clinical care.
4. Practice-Based Learning and Improvement: Stay current with medical literature and technology; analyze your experiences to improve your practice; facilitate learning of students and others.
5. Professionalism: Demonstrate integrity, honesty, and empathy; respect patients' autonomy and diversity; be timely and respond promptly.
6. Systems-Based Practice: Provide high quality cost-effective care; coordinate care effectively with other specialists; advocate for quality patient care in the system.

Each of the 22 ACGME Internal Medicine Milestones are linked to one of the 6 core competency domains listed above. The Milestones are designed for use in evaluation of residents in the context of their participation in our ACGME-accredited program.

#### *Clinical Competency Committee and Milestone Reporting:*

The ACGME's Next Accreditation System (NAS) requires semiannual submission of Educational Milestone data based on evaluations of resident developmental outcomes in the six core competency areas. The Clinical Competency Committee (CCC) is charged with reviewing resident evaluations during semi-annual meetings; preparing and assuring the reporting of Educational Milestone data from evaluations of each resident semi-annually to ACGME; and making recommendations to the Program Director for resident progress, including promotion, remediation, and disciplinary measures. The overall goal of the CCC is to ensure residents meet requirements for promotion and graduation. The Program Director (also Chair of the CCC) is responsible for setting the agenda for the meetings by identifying residents to be brought before the CCC, organizing and presenting the data to be discussed at the semi-annual meetings,

and implementing an action plan for residents whose evaluations indicate one or more deficiencies.

The CCC meets semi-annually in November and May to examine milestone data for each resident. The meetings occur prior to the semi-annual advisor/ resident meetings (fall and spring) and the annual Program Director/ resident meetings (spring). The Program Director or resident advisor communicates the CCC's decisions to the resident.

The CCC membership is synonymous with that of the Internal Medicine Education Cabinet. All members are voting members except the Chair of the CCC who is the Internal Medicine Program Director. Other faculty members, including Chief Residents, may be invited attendees to provide supplemental information to the committee but will be non-voting. CCC members and all other participants agree to keep all information regarding residents confidential except as required by terms of a given remediation or disciplinary plan.

The CCC Chair and the Program Coordinator review all resident evaluations on a semiannual basis and provide summative milestone assessments and recommendations to the CCC at the semi-annual meetings. The CCC can request additional information for potential problem areas. Consensus is obtained for the final Educational Milestones reported for each resident. The CCC Chair is charged with identifying residents who require special discussion by the CCC for potential adverse actions. Special discussions may occur during quarterly Education Cabinet meetings or at other times if urgency so requires. The CCC develops a plan of action for residents with academic or professional deficiencies; their decisions are communicated to the Program Director for implementation. Decisions regarding promotion, non-promotion and non-reappointment (as defined in the GMEC Policy 1.300) are determined by majority vote of the CCC.

After the review of each resident, possible recommendations from the CCC to the Program Director are:

1. No problem exists; resident is promoted or deemed board-eligible if training will be completed before the next CCC meeting.
2. Non-reportable actions – a problem exists and the resident is informed and steps are suggested for the resident to improve. This is considered an early intervention for quality improvement (QI) purposes only. The resident is promoted or deemed board-eligible if training will be completed before the next CCC meeting.
3. Reportable actions – a problem exists to the extent that adverse actions are required and the deficiency is such that future reporting to state medical boards, credentialing bodies, etc. is warranted. This is reserved for major deviations from expected performance. The CCC recommends a personalized remediation plan.
  - a. Non-promotion- the resident failed to perform at an acceptable level in the period of current appointment or cannot reasonably function satisfactorily at the next level and is not advanced to a higher rank or title. A non-

promotion does not necessarily equate to either non-reappointment or dismissal, but merely that the resident will not be advanced to the next level of appointment at the completion of the contract period.

- b. Non-reappointment- the resident is not offered a next successive contract for appointment at the end of the current appointment period (usually June 30). Non-reappointment is not a dismissal as governed by GMEC Policy 1.420 and, therefore, does not require cause.
- c. Non-graduation- Resident completes remaining contract term but does not receive final year credit or board eligibility.

Deficient areas upon which the actions are based and the final recommendations of the CCC are included in the minutes of the meeting. Minutes are kept on file by the Program Coordinator and brought to the future CCC meetings for all to review. Members of the CCC do not discuss their findings with the resident under consideration.

When the CCC recommends a reportable action, the Program Director, in consultation with the Department Chair and Vice Chair for Education, determines if additional disciplinary actions (Probation, Suspension, and Dismissal) are warranted. This occurs in accordance with GMEC Policy 1.420, and UAMS' institutional due process is followed.

In instances where a resident's agreement will not be renewed or when a resident will not be promoted to the next level of training, the Program Director will provide the resident with a written notice of intent no later than four months prior to the end of the residents' current agreement. If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the Program Director will provide the resident with as much written notice of the intent not to renew or not to promote as circumstances will reasonably allow, prior to the end of the agreement.

At the completion of the residency program, the Program Director prepares a summative evaluation which documents the residents' performance during the final period of education and verifies that the resident "has demonstrated sufficient competence to enter practice without direct supervision". This evaluation is accessible for review by the resident and remains in the program's files to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in the actions of other bodies.

### **Data to be Reviewed for Each Resident**

1. Data from end-of-rotation evaluations (from attendings, resident peers, and other members of the interprofessional team) are mapped to the 22 Educational Milestones to determine:
  - a. Individual mean scores and range for each of the 22 reporting milestones (scale is 0-4), comparison of individual mean scores with PGY means, trend of individual mean scores from year to year over time. *These data*

*will be reported to the ACGME.* (Note: individual resident scores in each milestone will be aggregated to the program level for use in NAS)

2. Other information for consideration
  - a. Comments from end-of-rotation evaluations
  - b. Patient evaluations
  - c. In-Training Exam scores (ITE results are *not* to be used to determine reportable or disciplinary actions)
  - d. Scholarly activities, including research
  - e. Completion of assigned ambulatory learning modules
  - f. Mini Clinical Examination Exercises (MiniCEX)
  - g. Conference attendance

### Evaluations:

We use multiple sources to evaluate residents. These sources include:

1. End-of-rotation evaluations by attendings based upon the rotation goals and objectives
2. Direct observations by attendings, using a mini-clinical examination (CEX) tool
3. Multisource (360) evaluations by interprofessional team members (nurses, social workers, case managers)
4. Peer evaluations (PGY2/3 evaluations of PGY1 and PGY1 evaluations of PGY2/3)
5. Self-evaluations
6. Patient evaluations
7. In-Training Exam results (for medical knowledge only)

For each rotation, attendings grade resident performance based upon the degree with which they trust the resident to attain/perform each objective at the conclusion of the rotation. In this context, each objective is an Entrustable Professional Activity (EPA).

The evaluation scale based on level of entrustment is:

0. You are unable to achieve the objective even with supervision
1. You can achieve the objective with direct supervision (supervising physician trusts you when he/she is physically present)
2. You can achieve the objective with indirect supervision (supervising physician trusts you when he/she is on-site or readily available by phone or electronic means and is available to provide direct supervision)
3. You can achieve the objective without supervision (independently)
4. You can achieve the objective at the level of an expert (aspirational)

The anticipated progression is for interns to move from level 1 entrustment to level 2 during the PGY1 year and for upper level residents to move from level 2 to 3 during the PGY2/3 years, so that by the conclusion of training you will be able to perform all entrustable activities without supervision and therefore be

ready to practice internal medicine independently. We expect very few, if any, residents to attain level 4 entrustment in any activity.

All UAMS residency programs use New Innovations software for evaluations. The Program Director or his designee plots your individual progression as you move through training based on all of your evaluations. The Department's Clinical Competency Committee (CCC) meets biannually to review your progress. Data based on the performance of each resident are transmitted to the Accreditation Council for Graduate Medical Education (ACGME) biannually in the form of 22 Reporting Milestones, which reflect your evaluations, which, in turn, reflect the degree with which your attendings and other evaluators trust you to perform the activities (i.e. attain the objectives) for every rotation.

#### Probation/Suspension/Dismissal

Actions of Probation/Suspension/Dismissal, as determined by the CCC as described above, follow the guidelines in the GMEC policy on Academic and Other Disciplinary Actions (1.420).

A resident involved in the disciplinary actions of probation, suspension and dismissal has the right to appeal according to the GMEC policy Adjudication of Resident Grievances (1.410).

### **POLICY: *Transferring Between Residency Programs***

In order to allow the current Program Director to make appropriate plans to fill a vacated position and to maintain professional relationships, ethical standards and program stability for residents and other program directors, the following procedure must be followed when a resident wishes to transfer to another program:

- Between programs sponsored by the UAMS College of Medicine (UAMS-COM), or
- From a program sponsored by UAMS-COM to a program sponsored by another institution, or
- From a program sponsored by another institution to a program sponsored by UAMS-COM.

It is unethical for a Program Director to initiate recruitment of a resident currently in a program at UAMS-COM or elsewhere and discuss specific positions or arrangements with the resident without first receiving written or verbal notification from the current Program Director. It is unethical for a resident to seriously pursue a transfer to a program within UAMS-COM or elsewhere without first discussing his/her plans with the current Program Director.

Failure to abide by the procedures outlined in the policies set by the GMEC Policy 1.210 may result in the resident not being allowed to transfer or the filing of a complaint with

the appropriate Residency Review Committee(s) of the Accreditation Council for Graduate Medical Education.

To determine the appropriate level of education for a resident who is transferring from another program, the Program Director must receive written verification of the previous educational experiences and a statement regarding the performance evaluation of the transferring resident, including an assessment of competence in the six general competency areas, prior to acceptance into the program. A Program Director is required to provide verification of residency education for any residents who may leave the program prior to completion of their education.

<b>Policy: <i>Resident Supervision</i></b>
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The Internal Medicine Program will supervise residents:

- to ensure the provision of safe and effective patient care
- to ensure that the educational needs of the residents are met
- to allow for progressive responsibility appropriate to the residents' level of education, competence and experience
- according to specific supervision requirements in the Internal Medicine Program Requirements

In compliance with the GMEC policy on Resident Supervision (3.100), the following guidelines are followed for supervision of Internal Medicine residents:

1. Qualified faculty physicians directly or indirectly supervise all patient care at each participating site (UAMS Medical Center, Central Arkansas Veterans Healthcare System, Arkansas Children's Hospital and Baptist Medical Center) and their schedules are structured so that adequate supervision is available at all times. Supervision is classified as "direct", meaning the attending is physically present, or "indirect", meaning the attending is immediately available by phone or other electronic means and able to be present if necessary.
2. At night and other off-hours, residents are able to identify their supervisory physician(s) by viewing the UAMS on call schedule at: [http://intranet.uams.edu/oncall/core\\_dayview.aspx](http://intranet.uams.edu/oncall/core_dayview.aspx)
3. Rapid, reliable systems for communication with supervisory physicians are available via cell phones and pagers.
4. Attending faculty physician supervision is provided appropriate to the skill level of the residents on the service/rotations.
5. Residents have progressive responsibility according to their level of education, competence and experience.
6. Specific responsibilities for patient care are included in the written description of each service/rotation; this information is reviewed with the resident at the beginning of the service/rotation and is available at any time via the UAMS Intranet and New Innovations.
7. The following procedure is to address fatigue of the resident:
  - a) The chief resident is contacted and arrangements are made for the jeopardy resident to relieve the resident.

- b) The chief resident determines when the resident should return to the education program.
- c) The chief resident notifies the attending faculty physician about these arrangements.

<b>Policy: <i>Duty Hours and Work Environment</i></b>
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In compliance with the UAMS College of Medicine GMEC policies on duty hours/work environment (3.200) and moonlighting (3.300 and 3.400) and considering that the care of the patient and educational clinical duties are of the highest priority, the following guidelines apply:

Duty Hours

- Duty hours are limited to 80 hours per week, averaged over four-weeks within the confines of a rotation's start and end dates and inclusive of all in-house call activities and supplemental clinical activities (e.g. moonlighting).
- Vacation or leave days will be taken out of the numerator and the denominator for calculating duty hours, call frequency and days off, i.e. if a resident is on vacation for one week, the hours for that rotation will be averaged over the remaining three weeks.
- First Year residents continuous duty must not exceed 16 hours.
- Upper level residents may be scheduled to a maximum of 24 hours of continuous duty. Four (4) additional hours are permitted for effective transitions.
- Residents can stay past 24 hours to care for a single patient (with justification).
- Residents may not attend clinics after 24 hours of continuous duty.
- All residents *should* have 10 hours off between tours of duty, *must* have 8 hours.
- Residents are provided one day (24 hours) in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, within the confines of a rotation's start and end dates and inclusive of call.
- Residents must not be scheduled for more than 6 consecutive nights while on night float.
- Residents are encouraged to use alertness management strategies in the context of patient care responsibilities.
- Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 pm and 8:00 am, is strongly suggested.
- The Program Director must ensure that residents are provided appropriate backup support when patient care responsibilities are especially difficult or prolonged.

The resident is expected to be on duty at least during normal working hours which are 7:00am to 5:00pm Monday through Friday. Often, clinical responsibilities will require longer hours, and professional behavior includes coming to the hospital as early as needed and staying as late as needed to accomplish all patient care tasks within the restrictions posed by duty hour requirements and appropriate management of fatigue. Additional duty hours beyond 5:00pm include on-call duties. Night, weekend and holiday call schedules are formulated by the faculty and/or chief

residents and depend on the specific educational rotation. Residents must be available by telephone or pager while on-call. Specific call systems and responsibilities are delineated in the written House Staff Guidelines booklet. Goals and objectives for each rotation are available to the resident in New Innovations prior to the beginning of every rotation.

### Work Environment

The Internal Medicine Training Program and the UAMS College of Medicine jointly ensure the availability of adequate resources for resident education, as outlined in the specific program requirements of the ACGME.

- **Meals:** food is available for residents 24 hours a day while on duty in all institutions.
- **Call rooms:** adequate and appropriate call rooms that are safe, quiet, and private are provided for all residents who take in-house call.
- **Ancillary support:** Adequate ancillary support for patient care is provided. Except in unusual circumstances, providing ancillary support is not the resident responsibility except for specific educational objectives or as necessary for patient care. This is defined as, but not limited to, the following: drawing blood, obtaining ECGs, transporting patients, securing medical records, securing test results, completing forms to order tests and studies, monitoring patients after procedures.
- **Pagers:** pagers are assigned at the beginning of the training period and a supply of batteries is available in the Internal Medicine House Staff Office.
- **Mail:** Individual mail boxes are assigned which are located in the house staff lounge.
- **E-mail:** E-mail accounts are issued by UAMS and must be checked daily.
- **Book Fund:** An educational book fund is furnished at each level of training.

### Moonlighting

In order to be eligible for moonlighting activities, the resident must follow the procedure as outlined in the GMEC Policy, *Moonlighting and Malpractice Insurance Coverage while Moonlighting* (GMEC Policy 3.300) and *Supplemental Clinical Activities* (also known as internal moonlighting) (GMEC Policy 3.400). Residents are **not** required to moonlight, and PGY1's are not allowed to moonlight. The resident must submit a written request to the Program Director and obtain his/her written approval. This information is contained in the resident's file. The resident must obtain a valid Arkansas Medical License for external moonlighting. Professional liability coverage (malpractice insurance) provided through UAMS does **not** cover external moonlighting (moonlighting activities outside of the UAMS hospital system). Malpractice insurance for such activities is the sole responsibility of the resident. It is the responsibility of the clinical facility hiring the resident to determine whether the appropriate credentials, adequate liability coverage and appropriate skill levels are in place.

In order to obtain written permission for moonlighting activities, the resident **must:**

1. Submit a plan or proposal for moonlighting activities to the Program Director.
2. Be in good standing and fulfilling all educational requirements of the program.
3. Not be delinquent in the medical records department.

4. **Record all hours spent moonlighting as duty hours in New Innovations. All working duty hours [moonlighting activity + residency- related duty hours] must NOT exceed the 80 hours/week duty limit. All other duty hour requirements also apply.**
5. Obtain a valid Arkansas Medical License (external only).
6. Obtain a malpractice insurance policy that will cover the activity to be performed outside the training program, or be certain that the employing facility provides adequate insurance coverage to protect the outside professional activities ['tail' coverage for claims filed after the time in employment in this activity is strongly recommended] (external only)].
7. Obtain a personal DEA number in the event Schedule II drugs are prescribed (external only).

The Program Director will terminate moonlighting privileges if the resident is no longer performing satisfactorily in the program. In the event permission to moonlight is withdrawn by the Program Director, the obligation to notify an outside employer is the responsibility of the resident who established that employment and not the responsibility of the Program Director or UAMS.

Residents will be subject to dismissal from the program for the following:

- Moonlighting without written approval of the Program Director.
- Continuing to moonlight after permission to do so is withdrawn.
- Using the University Hospital's or Arkansas Children's Hospital DEA number while moonlighting.

**INTERNAL MEDICINE TRAINING PROGRAM**  
University of Arkansas for Medical Sciences

**REQUEST TO PARTICIPATE IN MOONLIGHTING ACTIVITIES**

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4. Obtain a valid Arkansas Medical License (external only)
5. Obtain a malpractice insurance policy that will cover the activity to be performed outside the training program, or be certain that the employing facility provides adequate insurance coverage to protect the outside professional activities ['tail' coverage for claims filed after the time in employment in this activity is strongly recommended] (external only)
6. Obtain a personal DEA number in the event Schedule II drugs are prescribed (external only)

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2. Continuing to moonlight after permission to do so is withdrawn
3. Using the University Hospital's or Arkansas Children's Hospital DEA number while moonlighting

As a resident in the Internal Medicine training program, I understand and will abide by the above requirements for moonlighting activities. I understand that the performance of these activities will not interfere with my ability to achieve the goals and objectives of my training program. I request permission to engage in moonlighting activities.

\_\_\_\_\_  
Name resident (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Program Director

\_\_\_\_\_  
Date

Resident's File

### **Policy: Addressing Resident Concerns in Internal Medicine**

In compliance with the UAMS College of Medicine GMEC policy on Addressing Concerns in a Confidential and Protected Manner (GMEC Policy 1.400), the resident should follow these guidelines to raise and resolve issues of concern in a confidential and protected manner:

If a resident has any concern, the following approach is recommended:

1. A resident should discuss the concern with either the supervising-senior level resident or attending physician or the Chief Resident or the resident's assigned faculty advisor.
2. If the above discussion does not resolve the concern, the resident should meet with the Program Director or his designee.
3. If the issue is of such a nature that it cannot be discussed at the program level, or if the resident feels uncomfortable doing so, or the resident desires additional discussion, the resident should follow the following procedure:
  1. The resident contacts the Associate Dean for GME and/or a member of the Resident Council.  
<http://medicine.uams.edu/currentresidents/resident-handbook/resident-organization-and-resident-council/>
  2. If the resident wishes assistance from the Resident Council, the following steps should be followed:
    - a. The resident should contact at least two members of the Resident Council to schedule a meeting to discuss the problem confidentially.
    - b. The Resident Council members will meet with the resident and offer advice on how to resolve or handle the problem and if further steps are necessary. Based on the discussion and advice at this meeting, the resident may resolve the problem, and no further action is necessary.
    - c. If the resident's problem cannot be resolved or is of such a nature that further information is needed, the Resident Council members should discuss the problem with the Associate Dean for GME or the GMEC Chair.
    - d. In order to ensure easy access to Resident Council members they are posted in the Resident Handbook on the GME website
    - e. The procedure for resolution will vary depending on the type of issue:

For issues related to general work environment, the Associate Dean for GME (Dr. James Clardy) or Resident Council may discuss the issue and make recommendations for resolution through the GMEC. Issues related to disciplinary action will be addressed according to the procedure outlined in the GMEC policy on Disciplinary Action including Probation, Suspension and Dismissal. Issues related to maltreatment will be addressed according to the procedure outlined in the GMEC policy on Appropriate Treatment of Residents in an Educational Setting. Should a

resident believe that a rule, procedure, or policy has been applied to him/her in an unfair or inequitable manner or that he/she has been the subject of unfair or improper treatment, the resident should refer to the GMEC policy on Adjudication of Resident Complaints and Grievances. Discussions and recommendations by the Resident Council and/or the GMEC are confidential to the extent authorized by law and handled in a manner to protect the resident. A mechanism for reporting a lapse in professionalism on the part of a UAMS College of Medicine Physician (a faculty member or a resident) is available through the ILLUMINE web page at <http://medicine.uams.edu/faculty/faculty-databases/illumine>

### **Policy: *Effect of Leaves of Absence***

Internal Medicine resident physicians are in the unique position of having a role as students and employees. Although brief periods of leave can usually be accommodated, extended absences from the residency program for any reason may adversely affect both the resident's completion of the educational program on schedule and the program's responsibilities for patient care, allocation of clinical teaching opportunities and funding for resident stipends. The resident must take into account these factors when requesting extended periods of leave from the program. The program follows GMEC Policy 2.200; please see the complete policy at <http://medicine.uams.edu/files/2012/08/2.200-Leave-for-Residents.pdf>

### **The ABIM's Policies and Procedures for Certification include the following:**

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. Vacation leave is essential and should not be forfeited or postponed in any year of training and cannot be used to reduce the total required training period.

### **Leave for Exams**

There is a "**Request for Leave**" form you must obtain from the Residency Office for approval for leave taken for exams (USMLE 3, ACLS, etc.). This must be filed in the Residency Office **31 days in advance** of the leave requested. It is the resident's responsibility to arrange coverage. It is the responsibility of the resident to arrange coverage for elective exams taken during ward, unit, float, or IM consult rotations.

### **Educational Leave**

Educational leave can be taken to attend a medical conference with the approval of the Program Director. It is the responsibility of the resident to arrange coverage of any duties or clinics. The exception is if a resident is presenting a paper, poster, or abstract at the meeting, in which case the Chief Residents will help find coverage. The resident must submit proof of the meeting along with an educational leave request form from the Residency Office.

The Department will provide funding (maximum \$1,200.00) for a resident who presents a poster or oral presentation at a national conference. This can only be used for one meeting per academic year, and the resident must be first author. Keep in mind that the maximum reimbursement is \$1,200.00. The resident is responsible for any overages. All expenses should be paid by the resident initially. The resident must make all of her own travel and registration accommodations. The resident is reimbursed after he submits his documents to the house staff office.

Documents that need to be submitted and other actions required for Pre-Approval:

1. Front cover of conference brochure (or an email that has all of the information on it such as dates, etc.) and the agenda.
2. Paid Registration for conference.
3. Hotel registration – if made – not necessary, but preferable to get pre-approved. If conference hotels are more than the allowed daily per diem rate for hotels in that city, either shop lower priced hotels or share a room. If a room is shared, it is also necessary that each party pay separately for the hotel charge as only one person will be reimbursed unless there are separate receipts. If a resident chooses to stay at the conference hotel and does not share a room, she will have to absorb the additional cost of the room if it exceeds the allowed per diem rate. To view per diem rates go to UAMS's Travel website and look for Federal Per Diem Rates.
4. For food, tip allowance is no more than 15%. The resident will only be reimbursed for the actual amount spent on meals, provided it is NOT more than the per diem per day. A detailed receipts for meals, not just the credit card total, must be provided.
5. Tipping will NOT be reimbursed for taxis.
6. Money spent on alcohol will NOT be reimbursed. If alcohol is consumed, it must be paid for separately.
7. Submit for Pre-Approval at least 3 weeks prior to trip departure – 30 days would be preferable.

### **Vacation Leave**

Vacation leave for each house staff member consists of 21 days (three-7 day weeks). If the service to which you are assigned rounds on weekends or holidays, you are expected to be in attendance for work, even if you had vacation the day before or after that weekend or holiday.

PGY-1 residents are permitted to use up to 2 ambulatory weeks for vacation; PGY-2 and -3 residents are not permitted to use ambulatory weeks for vacation, except under rare circumstances. Med-Peds residents are not permitted to use ambulatory weeks for vacation.

It is absolutely necessary for you to submit your vacation requests for the entire three weeks to the Medicine Residency Office in July to enable coverage plans and proper billing for your vacation time. Only with special approval through the Medicine Residency Office can your original requests be changed. To make changes from your original requests, you **MUST** obtain a **“Request for Vacation Change”** form from the Residency

Office, get appropriate signatures and submit signed form to the Residency Office **90 days in advance**.

- PGY-1: Vacation may be taken during elective rotations except the Geri/Neuro rotation (unless that rotation is your third elective month; the vacation must come from the Geriatrics part of the rotation, not Neurology), the ED rotation (with prior approval from the ED), and up to 2 ambulatory weeks. General Medicine consult is eligible for vacation, provided there is another intern/upper level resident scheduled at the same time. Med-Peds interns may take vacation during the Geriatrics / Neurology rotation and/or their other elective rotation.
- PGY-2 and PGY-3: In order to attend interviews, a resident may elect to use his/her days off, whether from the monthly ones (4 days off a month) or from the yearly vacation (21 days). If not, the resident is expected to arrange coverage for the days when he or she will be off to interview. It is mandatory to inform the Chief Residents and the Residency Office of every interview/coverage that will take place to be able to keep track of the time off taken by the resident. **This policy only applies to residents attending interviews.**
- Prior to traveling out of state or abroad, you must submit a copy of your itinerary to the Residency Office. When a delay occurs, problems develop in scheduling. The delay often results in time being extended beyond the approved requested vacation dates. It will be up to the discretion of the Program Director, Associate Program Director and/or Chief Residents to decide whether you will have to pay back any extended time due to travel delays.
- You cannot carry vacation time over from one year to the next.
- No vacation time can come from the Wards, ACR, CCU, MICU, Float rotations, or Hem-Onc clinic.
- Time to attend meetings is vacation unless you are presenting a paper or unless you have made prior arrangements through the Medicine Residency Office.
- **No vacations except officially recognized vacation days will be allowed during the “Holiday Schedule/Mental Health Days”.**

### **Sick Leave**

Sick leave for unforeseen medical reasons will be granted with pay for a maximum of 12 days during each year of the residency program. Weekdays and weekend days during which the resident is assigned to work will be charged as sick leave if the resident is unable to work due to illness. Residents will not be charged sick leave for days on which they were not assigned to duty (i.e. scheduled days off). Sick leave cannot be carried over from one year to the next, nor will residents receive payment for unused sick leave at the completion of the program. To access sick leave a resident must notify the Chief Resident at their respective work location as well as the Residency Office. A resident may be placed on sick leave for extended periods of time (generally in excess of one consecutive week only) with the approval of the Program Director, according to the following procedure for extended sick leave:

1. The resident submits a written request to the Program Director stating the nature of the illness or injury and the reason for the requested extension of sick leave.

2. The request is reviewed by the Program Director who determines the effect of extended leave on continued participation in the residency program and the possible need for and availability of remedial training. This information must be provided to the resident in writing. The Program Director may require a statement from the resident's treating physician to help in these determinations.
3. The Program Director must notify the Assistant Dean for House Staff Affairs about the planned leave period. FMLA paperwork will be completed for any illness that is expected to cause leave of more than a few days.
4. Unused vacation time must be used after the exhaustion of sick leave. When maximum sick leave and vacation time have been exhausted, the resident is placed on leave without pay.
5. The Program Director shall decide whether the resident may return to full duties upon consideration of all circumstances involved. The Program Director may require a statement from the resident's treating physician to help determine if the resident is medically qualified to return to duty and if any restrictions are necessary in the resident's clinical activities because of the illness.
6. Under special circumstances, the resident may request permission to start and complete one year of residency program over a two-year period. Such requests must be made in writing and in advance to the Program Director. Approval will be based upon the educational curriculum of the program, the requirements of the clinical service, and the Residency Review requirements of the residency program.

#### **Special Provisions for Pregnancy:**

In recognition of the physical demands of the residency program and to ensure optimum consideration for both the mother and the unborn child, the following procedures should be followed:

1. When the pregnancy is confirmed, the resident should notify her Program Director promptly.
2. The Program Director will be sensitive to the confidential nature of this information during the early part of pregnancy.
3. By the end of the sixth month of pregnancy, the resident must provide the Program Director with a written statement about the expected date of delivery, and the intended dates of leave. Any subsequent change in medical condition that might alter this information should be submitted in a revised statement.
4. The Program Director may request a statement from the treating physician, especially in the case of extended leave.
5. See UAMS Administrative Guide No. 4.6.11, Family and Medical Leave Act (FMLA) if leave is without pay or if she elects to take a leave of absence without pay before exhausting her unused sick and vacation time.
6. FMLA paperwork will need to be completed regardless of paid or unpaid time off taken, and it is the responsibility of the resident to ensure that this is completed.

#### **Parental Leave:**

1. The maximum period of parental leave with pay is 33 days (12 days of unused sick leave plus 21 days of unused vacation time). Time off-duty beyond that amount is

without compensation. Parental leave must be taken at the time of the birth and all of the time will be taken together and cannot be split up.

2. Time off for parental leave must be requested in writing to the Program Director as soon as it is known, preferably at least four (4) months before the date of the leave.
3. The Program Director will consider all aspects of the residency program in granting or denying permission for leave.
4. See UAMS Administrative Guide No. 4.6.11, Family and Medical Leave Act (FMLA) if leave is without compensation.

### **Bereavement Leave:**

Sick leave may be granted to employees due to the death or serious illness of a member of the employee's immediate family. Immediate family is defined as the father, mother, sister, brother, spouse, child, grandparent, grandchild, in-laws or any other person acting as a parent or guardian of an employee. The Program Director may grant sick leave for death or family illness in an amount which is reasonable for the circumstances.

<b>Policy: <i>Fatigue</i></b>
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The Internal Medicine residency program is committed to preventing and counteracting the potential negative effects of fatigue on resident well-being, learning, and patient care. Both faculty and residents are required to complete an educational program about sleep loss and fatigue. Residents are also required to complete a WebCT module, SAFER (Sleep, Alertness, and Fatigue Education in Residency). The GMEC pamphlet on fatigue education is distributed to residents annually to educate them on the signs and symptoms of fatigue. A short video on how to recognize and manage fatigue effectively can be found at <http://medicine.uams.edu/current-residents/gme-videos/>. The Program Director and supervising faculty monitor the demands of individual rotations and call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue. Individual monitoring for signs of fatigue occurs semiannually at every resident/advisor meeting. Call rooms are available for napping when a resident becomes too tired to continue their duties or safely travel home.

### **Fatigued residents typically have difficulty with:**

- Appreciating a complex situation while avoiding distraction
- Keeping track of the current situation and updating strategies
- Thinking laterally and being innovative
- Assessing risk and/or anticipating consequences
- Maintaining interest in outcome
- Controlling mood and avoiding inappropriate behavior

### **More specifically, signs of fatigue include:**

- Involuntary nodding off
- Waves of sleepiness
- Problems focusing
- Lethargy

- Irritability
- Poor coordination
- Difficulty with short-term recall
- Tardiness or absences at work

High risk times for fatigue-related symptoms are:

- Midnight to 6:00 AM
- Early hours of day shifts
- First night shift or call night after a break
- Change of service
- First 2 to 3 hours of a shift or end of shift
- Early in residency or when new to night call

Moves to limit fatigue-related problems include:

- The 80-hour limitation to which our programs are held will certainly help reduce the total number of hours worked.
- In general, the residency workload should allow for as little variation in work schedules as is feasible.
- Rapid or frequent shifts from day to night work are known to increase the risk of fatigue.
- Many physical illnesses can present as fatigue and should be ruled out when daytime fatigue seems out of proportion to the resident's workload. The resident should be encouraged to consult his/her primary care physician. Sleep studies may be warranted.
- Depression and other psychiatric syndromes may first be manifest as fatigue. Proper diagnosis and treatment should be recommended.

In the event a resident experiences fatigue severe enough to interfere with his/her ability to function normally or to impair patient care or safety, the resident, chief resident or a faculty member will contact Dr. Saccente, the Program Director. If Dr. Saccente is not available, the report may go to Dr. Vyas, Associate Program Director at UAMS or Dr. Robert Bradsher, Vice-Chairman for Education.

The resident will nap in the 3<sup>rd</sup> floor call room until he/she can return to their clinical duties or safely drive home. The faculty member or the one who receives the original report of resident fatigue will notify the Chief Resident who will arrange coverage through the jeopardy system if needed. The Chief Resident will also report the incident to the Program Director by telephone or e-mail, if the program director was not involved in the original report.

In the event a resident experiences recurrent problems with sleepiness/fatigue, Dr. Saccente will refer the resident for medical evaluation or counseling as appropriate.

**Policy: *Physician Impairment- fatigue or substances***

The Internal Medicine Program explicitly follows GMEC Policy 2.300, which can be found at <http://medicine.uams.edu/files/2015/06/2.300-Impairment.pdf>

Signs and symptoms of impairment may include, without limitation, the following:

- Physical signs such as fatigue, deterioration in personal hygiene and appearance, multiple physical complaints, accidents, eating disorders.
- Disturbance in family stability or evidence of personal or professional relationship difficulties with resulting isolation.
- Social changes such as withdrawal from outside activities, isolation from peers, embarrassing or inappropriate behavior at parties, adverse interactions with police, driving while intoxicated, undependable and unpredictability, aggressive behavior, argumentative, or unusual financial problems.
- Professional behavior patterns such as unexplained absences, spending excessive time at the hospital, tardiness, decreasing quality or interest in work, inappropriate orders, behavioral changes, altered interactions with other staff, inadequate professional performance or significant change in well-established work habits.
- Behavioral signs such as mood changes, depression, slowness, lapses of attention, chronic exhaustion, risk taking behavior, excessive cheerfulness, and flat affect.
- Signs of drug use or alcohol abuse such as excessive agitation or edginess, dilated or pinpoint pupils, self-medication with psychotropic drugs, stereotypical behavior, alcohol on breath at work, uncontrolled drinking at social activities, black outs, binge drinking, changes in attire (e.g., wearing of long sleeve garments by parenteral drug users).

Repeated evaluations documenting substandard academic performance or other grounds for consideration by the residency training program director of academic probation or remedial work, existing in conjunction with one or more sign(s) or symptom(s) of impairment, such as those listed above, may be considered in determining whether or not medical and/or psychiatric evaluation of the resident in accordance with the procedure below is warranted. Members of the UAMS and ACH Medical Staff Health committees and staff members of the Employee Assistance Program (EAP) are available to assist in confirming or validating suspected abuse, dependency and/or impairment.

### **Policy: *Admissions***

#### **ADMISSIONS: University Hospital**

Admissions to the Internal Medicine services may come as direct admissions from a UAMS physician/clinic, transfers from other facilities/physicians, or through the emergency department. All patients are to be seen promptly by the accepting service or by the resident on duty if the patient arrives after hours. The patient is to be seen by both the intern and the resident and appropriate documentation should be performed. A single intern can be responsible for ongoing care for no more than 8

new/comprehensive admission evaluations in a 48-hour period or 5 admission evaluations in a 24-hour period. An upper level resident can be responsible for ongoing care for no more than 16 complete admission evaluations in a 48-hour period or 10 in a 24-hour period. General medicine/ Direct Care Hospitalist attending physicians or their designated Advanced Practice Nurse accept all medical admissions and assign teams. Admissions in excess of caps on admissions and team number caps will be admitted by the Direct Care Hospitalists.

### **General Medicine, Cardiology/CCU, Abernathy Infectious Disease, and Heme-Onc**

All non-MICU/non-CCU admissions (i.e. admissions from the emergency department, direct admits from clinic, and transfers from other facilities) will be assigned to a team by the General Medicine or Direct Care Hospitalist attending on call or the designated APN as follows:

1. **General medicine** patients will be assigned in a round-robin fashion to **3A, 3B, 3C, 3D, 3E, and 3F**.
2. Patients being admitted for cardiovascular problems (chest discomfort, heart failure, syncope, arrhythmias, etc.) and admissions to CCU will be assigned to **Team 1 Cardiology**.
3. Cancer patients actively followed by our Oncology clinic with solid tumors, including breast cancer patients followed by Dr. Hutchins, will be assigned to **Team 2A**.
4. Cancer patients actively followed by our Oncology clinic with hematologic malignancies will be assigned to **Team 2B**.
5. HIV patients followed by our Infectious Diseases Service and patients being admitted primarily for an infectious diseases problem that would normally generate an immediate ID consult will be assigned to the Abernathy ID Team (**Team 6**).
6. **Geriatrics** patients followed by the Reynolds Center should be admitted in the regular round-robin rotation to all the general medicine services (**3A, 3B, 3C, 3D, 3E, 3F**).

Each team will be responsible for admissions to their team until the short call period starts at 16:00. When the resident on Team 6 is off, the intern on Team 6 will still be responsible for admissions to Team 6 with supervision from the on call resident.

Once short call begins at 16:00, team censuses will be reconciled. Any team that has reached its cap will no longer be assigned admissions. (The one exception is Team 1 Cardiology, which has a rolling cap throughout the day and team census numbers are reconciled as patients are admitted/discharged).

The two residents and one intern on call will be responsible for all admissions to the teaching service for the short call period of 16:00-19:00. After 16:00, admissions should be assigned in a round-robin fashion with a 2:2 ratio with the non-teaching teams (including cardiology, ID, and Hem/Onc admissions).

From the period of 19:00-07:00, the night float resident and two interns will be responsible for all admissions to the teaching service, and in addition will be responsible for admissions to Team 2B.

Admit Log:

- The admit log template can be found in the medicine drive. Copies can be printed in any of the workrooms.
- *Every* admission, regardless of team assignment, should be written down on the admit log. This log should be passed to the night float resident with a face-to-face handoff on the admissions.
- The night float resident should reconcile the admit log and EPIC team lists (including expected direct admissions) prior to the end of every shift. It is the responsibility of the night float team to clearly communicate any team re-assignments with both the teaching and non-teaching services.
- The night float team should update the white board in the F6 workroom no later than 05:30 unless there are urgent patient care issues. The night float team must provide face-to-face handoff for admissions after 16:00 to the appropriate teams in addition to handoff about other patients.

### **Medical Intensive Care Unit (MICU)**

The MICU call team is responsible for all admissions (ED, transfers from other services, and direct).

### **ADMISSIONS: VA Hospital. Gen Med Teams 1, 2, and 3**

General Medicine admissions:

The Direct Care Hospitalists (DCHs) will be responsible for assigning all admissions to all general medicine teams, both teaching teams (Gen Med 1, 2, and 3) and the Direct Care Hospitalist Teams including admissions from the ED, clinics, NLR VA, and other facilities.

- 1) From 07:00-16:00, the DHC will assign admissions to medicine teams and will contact the on call resident with admissions. All medicine admissions between 07:00-16:00 will be assigned to the medicine teaching services, except for conference time, defined as 11:30 to 13:30. On days where the resident is off, that respective team will not be included in the round robin and will not receive admissions before 16:00.
- 2) From 16:00-19:00, the short call resident and two interns will be responsible for all admissions assigned to the teaching teams.
- 3) From 16:00 – 19:00, all admissions will be assigned in a 1:1 ratio between medicine teaching services and DCH teams.
- 4) The DCH teams will take most admissions with low educational value including acute alcohol intoxication, post-procedure observation, patients with primarily social issues, etc.
- 5) Once a teaching team reaches a soft cap of 12 patients, this team falls out of the round-robin rotation. Once all Gen Med teaching teams are capped, all admissions are the responsibility of the DCHs until they are all capped at 12 (and vice versa). When all teams are capped at 12, all subsequent admissions will be shared equally in a round robin fashion until all teams reach 14. **Fourteen is a hard cap for the**

**teaching teams.** If all teaching and DCH teams reach 14, all subsequent admissions are the responsibility of the DCHs.

Cardiology admissions:

- 1) All admissions assigned to the cardiology team and CCU are the responsibility of the residents and interns on Team 7/CCU from 07:00-16:00.
- 2) From 16:00 to 19:00, admissions assigned to Team 7 are the responsibility of the short call resident and interns. Admissions to the CCU from 16:00-19:00 will be the responsibility of the ICU resident and intern on short call.
- 3) From 19:00-07:00, admissions assigned to Team 7 are the responsibility of the night float resident and interns and CCU admissions are the responsibility of the ICU night float resident and intern.
- 4) Once Team 7/CCU reaches a cap of 20 patients or 10 new in a 24 hour period, admissions are no longer assigned to this team.
- 5) Patients admitted after an EP procedure are admitted by the cardiology APN from 7:00-16:00. After 16:00, these are the responsibility of the resident on call. These patients do count toward the team cap of 20.
- 6) Patients admitted post PCI after outpatient cath are admitted and cared for by the Interventional Cardiology team (staffed by fellows and the interventional cardiology attending). These patients do not count toward the Team 7 census.
- 7) Patients admitted solely for pre-cath hydration are to be admitted by the Interventional Cardiology team (Cardiology fellows) and staffed with the interventional cardiology attending. These patients do not count toward the Team 7 census.

Hem/Onc admissions:

- 1) Hem/Onc admissions are the responsibility of the Hem/Onc Team from 07:00-16:00.
- 2) From 16:00 to 07:00 the on call DCH is responsible for admissions to the Hem/Onc Team and these will count in the round-robin of admissions.

<b>Policy: <i>Patient Load</i></b>
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**University Hospital Ward Teams:**

Team 1 Cardiology/CCU: Team 1 is comprised of two upper level residents, one intern, and a CCU fellow who are responsible for covering both the inpatient cardiology and CCU services. The cap on this team is 14 patients.

Hematology-Oncology Team 2A: Team 2A is comprised of 1 resident, 2 APNs and 1 H/O fellow. Team 2A patients have primarily solid organ malignancies. The role of the resident on the team is to participate in the care and the treatment plan of a maximum of 16 patients per day. The fellow is responsible for overflow patients beyond 16 on any day. The resident is responsible for cross-covering for any overflow patients while the fellow is in clinic (this does not include pre-rounding). On weekdays, the resident is responsible for pre-rounding, placing orders, writing acceptance notes and H&Ps, and contacting

consultants while the APNs write progress notes and discharge summaries. All discharges are to be completed by the APNs. On weekends and holidays, the resident is responsible for a maximum of 10 progress notes in addition to other duties.

Hematology-Oncology Team 2B: Team 2B is comprised of fellows and APNs, no residents. The resident will assign admissions during the day. Residents cross-cover this team at night.

General Medicine Teams 3A/3B: The teams are comprised of 2 residents and 2 interns. These are the main teaching teams for medical students. These teams cap at 16 patients.

Abernathy Infectious Diseases Team 6: This team is comprised of 1 resident and 1 intern. This team also has a varying number of medical students. The team caps at 12 patients. The cap drops to 10 patients when the resident is off.

### **CALL SYSTEM: University Hospital**

Cross-coverage: Resident and intern short call occurs from 16:00-19:00 Monday through Friday. On weekends and UAMS holidays, short call starts at 12:00-19:00. Residents and interns who are not on call may start handoff as early as 12:00. Face-to-face handoff with an accurate, concise patient list *must* occur for every team at every level (resident and intern). Night float residents and interns should arrive **15 minutes prior** to the start of their shift to receive handoff.

#### Call Responsibilities:

Interns and Cover 1: The primary responsibility of interns is responding to pages from the floors as well as admitting patients assigned to their respective teams. Pages must be answered promptly and professionally, and any significant interventions should be documented in the EMR. Wise uses of free time include reading, following up on clinic patients or other patient needs, reviewing MKSAP questions, etc.

Residents: The primary responsibility of residents is to supervise the care of patients on the floor and new admissions. Residents are ultimately responsible for admissions during their call shifts but should allow interns to complete orders, H&Ps, etc. Time should be given to intern and medical student education during free time-periods.

Code Blue Team: The on-call resident and interns must respond **immediately** to all code pages and start appropriate triage and resuscitation efforts until the MICU team arrives. The MICU resident is the code team leader and should establish that role quickly upon entering the room. The rest of the code team should assist with obtaining information from the EMR, calling family or the patient's primary team, providing chest compressions, etc.

#### **Night Float System:**

The night float system is made up of one night float resident and two night float interns. From the period of 19:00-07:00, the night float resident and two interns will be responsible for all admissions to the teaching service, and in addition will be responsible for

admissions to Team 2B. They are also responsible for all call duties as noted above in the section entitled "Call Responsibilities."

### **MICU: University Hospital**

The MICU is comprised of 2 teams with 2 residents and 2 interns per team with 1 pulmonary/critical care fellow for both teams, and an acute care resident (ACR) to help with admissions/transfers. Team 1 takes short call on odd days. Team 2 takes short call on even days. MICU night float consists of 1 resident and 1 intern. Residents can expect 4-6 nights per block. Interns have 2 sets of 3-4 nights per block. All residents receive an average of 1 day off per 7 while in the MICU. MICU rounds begin at 08:00. When 2 interns are present, they are responsible for dividing the patients for a maximum 10 patients.

The MICU curriculum includes MICU-specific conferences. These are **mandatory** unless a resident or intern has a previously scheduled off-day or is on night float. The MICU team should attend all other conferences as patient care allows.

The MICU short call and night float also cross-cover the CCU patients. The Cardiology Team must provide an accurate/concise list and face-to-face handoff to the MICU call team every day there are CCU patients.

Coverage for the MICU admissions is as follows:

- 07:00-16:00: Acute care resident (ACR) is responsible for all admissions and transfers from the floor. The MICU call team is still responsible for code blue transfers.
- 16:00-18:00: MICU Resident on call is responsible for all admissions and transfers from the floor.
- 18:00-23:00 The Pulmonary Fellow on call is responsible for admissions M-F; on Saturday, Sunday, and holidays, a moonlighter takes the place of the Pulmonary fellow, but stays until 24:00.
- 23:00-07:00: The MICU Night float team is responsible for MICU and CCU admissions and transfers from the floor. The Pulm/CC and Cardiology fellow, respectively, **MUST** be called for all admissions.

The responsibilities of the ACR are as follows:

- 07:00-16:00: acute care resident (ACR) is responsible for all admissions and transfers from the floor.
- Work schedule is Monday-Friday from 07:00-16:00, no weekends, no holidays

### Transferring patients out of MICU:

It is the responsibility of the MICU teams to choose the appropriate team for transfer when a patient is stable for floor or stepdown. All teams must be called with a handoff prior to the patient transferring (resident to resident/attending, intern to intern). Transfers should be assigned in a round-robin fashion with a 2:2 ratio of transfers to the Gen Med teaching teams and the DCH teams. Patients who were previously on a team should be transferred back to that respective team. Patients whose primary illness is infectious can be transferred to Team 6.

Code Blue Team:

The MICU resident is the leader of the code team and should respond immediately to all code pages. The ward resident should defer to the MICU team once they arrive at a code on the floor. Regardless of the outcome (transfer to the ED or the MICU), a member of the code team should remain at the bedside of a living patient until final disposition is reached.

VA Hospital Ward Teams:

The general medicine service at the VA is composed of four teaching teams and several non-teaching teams. There is also a cardiology team on the teaching service.

<b>Team 1:</b>	<b>GENERAL MEDICINE</b>
<b>Team 2:</b>	<b>GENERAL MEDICINE</b>
<b>Team 3:</b>	<b>GENERAL MEDICINE</b>
<b>Team 7/CCU:</b>	<b>CARDIOLOGY</b>

**Teams 1-3** include an attending physician, one resident, two interns, and medical students who vary in number from month-to-month. These teams have a cap of soft 12 and a hard cap of 14 patients as explained above.

The cardiology team (**Team 7/CCU**) consists of three residents and two interns and the cap is 20 patients total, 10 new admissions daily. After this, the team is considered capped and the admissions are then distributed as general medicine admissions.

**NIGHT FLOAT SYSTEM: VA Hospital**

The VA night float rotation is comprised of one resident and two interns. As noted above, the night resident and interns are responsible for all patient care on the teaching service including the three general medicine teams and Team 7. They are also responsible for all admissions assigned to the teaching service from 19:00-07:00 unless teams are capped.

Residents and interns work in a 6 night on and 1 night off rotation. Interns on night float work Sunday-Friday night and will be off Saturday night. Interns from the Gen Med teams 1-3 will be assigned one Saturday night call 19:00-07:00 per block to cover the night intern's night off. This intern covering the Saturday night call will be expected to stay for morning rounds, to round on up to 4 patients and are required to leave by 11:00. Residents on night float work Monday-Saturday night and will be off Sunday night. Residents on the Gen Med teams 1-3 and the Team 7 resident will be assigned one Sunday long call (24h call) to cover the night resident's night off.

**CALL SYSTEM: VA Hospital**

Residents and interns take call from 16:00-19:00 Monday-Friday. Residents take long call on Sundays from 07:00-07:00 the next day. On long-call days, the on-call resident is responsible for all admissions assigned to the General Medicine teams and Team 7

between the hours of 07:00-07:00 the next day. On-call interns are expected to help with the admission process.

As noted above in the section on night float, the interns on Gen Med 1-3 will be assigned one Saturday night call 19:00-07:00 per month to cover the night intern's night off. This intern covering the Saturday night call will be expected to stay for morning rounds to round on up to 4 patients and are required to leave by 11:00.

Intern 1 covers the patients on Gen Med Team 1 and 2 along with the patients from Team 7 whose last name begins with A-L. Intern 2 covers the patients on Gen Med Teams 3 and 4 along with the patients from Team 7 whose last name begins with M-Z.

### **MICU: VA Hospital**

The MICU team consists of a pulmonary/critical care attending physician, a pulmonary/critical care fellow, an upper level resident, three to four interns, and a unit night float resident.

Coverage for the MICU/CCU admissions is as follows:

- During the hours of 07:00-16:00 (M-F), the MICU resident will be responsible for all MICU admissions (Direct, from the ED or transfer from the floor).
- On days when the MICU resident is off, the interns will be responsible for all MICU admissions with direct supervision by the MICU fellow
- During the on-call hours on weekdays and weekends, the MICU/CCU resident on call covers all admissions.
- During the hours of 19:00-07:00 (Monday-Saturday), the MICU night float resident covers the admissions.
- The interns in the MICU/CCU rotate in a "mole" system where each intern works night shifts from 19:00-07:00 for up to six nights at a time. This allows interns to participate in the educational opportunities that arise from taking care of patients while on call.
- For all admissions, MICU resident or CCU resident MUST call the pulmonary/critical care fellow on call for acceptance to the MICU, or the cardiology fellow on call for acceptance to the CCU. The fellows then call the on-call attending to discuss the case.

### **Policy: *Teaching Rounds***

Attending physicians on the wards, critical care units, and consult services are required to conduct daily rounds with residents. Times will vary depending on the nature of the service, but ward and MICU teams always round in the morning, and rounds usually last around 2 hours. These rounds should be equally divided between pure teaching involving case examples and work rounds with the team seeing each patient on the service. The attending is responsible for educating both the residents and medical students. When possible, teaching rounds will include people from other disciplines. Pharmacists, nutritionists, and nurses, for example, can provide valuable education and insight to residents and medical students during their training.

**Policy: *Non-Teaching Patients***

There are some patients both at the University Hospital and the VA Hospital who are not admitted to a teaching service, but rather Direct Care Hospitalist (DCH) teams. The care for these patients is not the day-to-day responsibility of the Internal Medicine residents; their hospitalist attending physician (and/or their delegates, who are not trainees) will deal with routine situations. Occasionally these patients will develop a need for acute care and will be evaluated by the resident either on an emergent basis at the request of nursing staff or in evaluation for transfer to the in-patient service or ICU by request of the primary physician. This emergent evaluation is considered to be critical to the education of residents in Internal Medicine. Preliminary and Internal Medicine residents may participate in elective rotations at Arkansas Children's Hospital and Baptist Health Medical Center. At these facilities there will be many non-teaching patients. The resident will not have responsibility for these patients but will, of course, participate in emergency care if needed.

## Policy: *Order Writing*

### **UAMS Medical Center & Central Arkansas Veterans Healthcare System**

#### **Ward Services:**

Essentially, all admissions as well as daily orders are to be written by the resident, primarily the intern and secondarily the upper level resident. Orders are not ordinarily written by the attending physician or consultation services unless agreed upon by the residents. Specialized orders (chemotherapy, dialysis, etc.) should be written by the subspecialty service. At the time of discharge, the intern is responsible for completing discharge orders in a timely manner. Whenever possible, these orders should be written the day prior to the patient's discharge. At UAMS, the resident is responsible for a written discharge summary to be completed in a timely manner. The intern is responsible for this written discharge summary at the VA Hospital. *Orders should not be written by the attending physician or by consultants for patients on medicine teaching teams except in rare circumstances. Put in other words, the only people who write orders for patients on internal medicine teaching teams are the internal medicine residents on those teams.*

#### **ICU:**

As on the ward services, the intern should be responsible for the writing of orders; however, as the patients are critically ill there will be more instances when orders are written on an emergent basis by the resident, fellow, or attending. Orders are not to be written by consultation services except as outlined above. The responsibility for the medical record is the same as on the ward service. An attending note should be written shortly after admission on every patient, and daily progress notes are required.

#### **Ambulatory Services:**

It is the resident's responsibility to document all findings and plans accurately within a well-organized clinic note. The resident writes all orders for the clinic encounter. The attending physician must see the patient as is appropriate with subsequent documentation by a clinic note.

#### **Consultation Services:**

It is the resident's further responsibility to ensure that recommendations are transmitted accurately with a well-organized chart note. The note should detail the reasons for the suggested studies or changes in management and not be a list of directives to the ward team or to the residents on another service. If the primary service requests the consulting internal medicine resident write orders, he does so.

### **Arkansas Children's Hospital & Baptist Health Medical Center**

Regulations governing the writing of orders for patients and the extent of bedside teaching shall be in compliance with the policies of Arkansas Children's Hospital and Baptist Health Medical Center and its professional staff according to the guidelines developed in cooperation with the Operations Committee of the respective hospitals.

## **Policy: *Supervision and Responsibilities***

### **In-Patient Services**

#### **Ward Services:**

PGY-1 residents: Residents in their first year of training for categorical Internal Medicine and the first 12 months of Medicine-Pediatrics (internship) are responsible for day-to-day management of patients admitted to the Internal Medicine wards. On admission, a complete history and physical should be performed by the intern and charted in the permanent medical record. Additionally, all admissions and daily orders are to be written by the resident, primarily the intern and secondarily the upper level resident. Orders are not ordinarily written by the attending physician or consultation services unless agreed upon by the residents primarily responsible for the patients (see above; residents must be “in-the-loop” for all aspects of care of their patients). Specialized orders (chemotherapy, dialysis, etc.) should be written by the subspecialty service. The intern is also expected to see each patient at least twice daily and to write a daily progress note. Medical students should be encouraged to write a history and physical and progress notes on each patient they follow; however, these are in addition to the required intern notes. At the time of discharge, the intern is responsible for composing a typed or dictated (electronic) discharge note and completing discharge orders in a timely manner. Whenever possible, these orders should be written the day prior to the patient’s discharge. The written discharge summary is the responsibility of the intern at the VA hospital. If the patient had no primary care physician prior to admission, he or she should be assigned to the intern’s continuity clinic to allow for long term follow-up for the patient and an educational experience for the intern.

PGY-2/3/4 residents: Residents in their second and third year of categorical Medicine training are expected to guide and supervise the care of each patient. The resident should perform a history and physical exam on each patient admitted to the Internal Medicine wards, and a resident admission note should be written. If this is done by a resident who will not follow the patient during the hospitalization (night float or short call resident), the resident assigned to the in-patient team must write a resident accept note within 24 hours of admission. If a resident or faculty physician at UAMS cares for the patient on an outpatient basis, the resident is to notify that physician of the patient's admission and condition. Every attempt should be made to notify referring physicians outside of UAMS of a patient’s admission and condition.

The resident is responsible for formulating a diagnostic and therapeutic plan for each patient. To fill this role, the resident should always be available to the intern and should know the patient’s condition, laboratory data, medications, and any other information necessary to formulate a therapeutic plan. The resident should see the patient at least daily, apart from work and teaching rounds, and should review the chart daily. All student notes must be co-signed by the resident. The resident is also responsible for the performance (and resulting data interpretation) of all invasive procedures on the patient. Interns are encouraged to perform these procedures under the direct supervision of the resident and the attending when available. Procedures should be discussed with the attending to ensure they are necessary prior to obtaining written consent. The resident is to ensure that discharge planning is adequate and to ensure

that a discharge summary is complete and in the medical record before the patient leaves the hospital.

Residents in Internal Medicine are also expected to provide active supervision and teaching of medical students. Residents play a vital role in instruction of medical students, and these activities are an important part of training of Internal Medicine residents. The resident should assign patients to students as they are admitted and should ensure a balanced experience for each student. The resident should conduct daily teaching rounds for the students.

ATTENDING PHYSICIANS: The attending physician is expected to see every patient within 24 hours of admission. He/she is to write a note describing and confirming the patient's history, examination, problem and the diagnostic and therapeutic plans. The attending physician is also encouraged to discuss topics relevant to the patients on the service with the students, interns, and residents. The attending physician is to see every patient on the service daily and to write a daily progress note. The attending must take responsibility to ensure that all of the clinical decisions made on the patient are appropriate. Residents are to be taught how to arrive at those decisions, and as competence is proven the resident should be given the opportunity to make supervised clinical decisions. Orders should not be written by the attending physician except in rare circumstances. He or she must be certain that therapy is appropriate, that diagnostic studies and particularly invasive procedures are necessary, cost-effective and efficient, and that high quality care is provided. Specific issues requiring attending input [and documentation of this in the medical record] include: changes in resuscitation status, escalation of care [e.g. transfer to ICU from 'ward', transfer to another service, significant [associated with escalation in risk of mortality or extension of length of stay by > 24 hours] events, patient death, and/or discharge from hospital or departure from the hospital against medical advice.

The attending also has an obligation to provide high quality instruction in diagnosis, treatment and pathophysiology to both the residents and students on the service. Clinical rounds must be balanced into both work rounds and teaching rounds at the bedside (see teaching rounds below).

Intensive Care Units:

PGY-1/2/3/4: The intern and resident are both expected to interview and examine every patient promptly on admission to the ICU or CCU or when called for a critical patient in the emergency department or on a ward. After that is completed and any urgently needed investigation or therapeutic measures have been instituted, the fellow and the attending physician on the service should be notified of the patient's admission and condition. In critically ill patients, very frequent observations and examinations are required. The resident must be aware of minute-to-minute changes in the patient's condition. The upper level resident is expected to make decisions and to be the primary caregiver for the patient by exercising keen clinical judgment and seeking advice, support and agreement from the fellow and attending physician. As on the ward services, the intern should be responsible for the writing of orders; however, as the

patients are critically ill there will be more instances when orders are written on an emergent basis by the resident, fellow, or attending. Orders are not to be written by consultation services except as outlined above. The responsibility for the medical record is the same as on the ward service (see above).

It is expected that rotations in the intensive care units will provide experience in invasive procedures. The resident may undertake, or supervise the intern on, procedures with which he or she has had adequate experience. Critical patients often require procedures (e.g. pulmonary artery catheterization, elective cardio version) that are done rarely out of an ICU setting. In these cases, the procedure must be supervised by a fellow or attending physician.

**ATTENDING PHYSICIANS:** The attending physician is responsible for all of the patient's care during the time in the ICU. The attending should be notified immediately of the patient's admission and should see each patient within a few hours. An attending note should be written shortly after admission on every patient, and daily progress notes are required. As on the ward services, education and teaching rounds are an important part of the attending physician's responsibility. Specific issues requiring attending input [and documentation of this in the medical record] include: changes in resuscitation status, escalation of care [e.g. transfer to ICU from 'ward', transfer to another service, significant [associated with escalation in risk of mortality or extension of length of stay by > 24 hours] events, patient death, and/or discharge from hospital or patient departure from the facility against medical advice.

### **Consultation Services**

PGY-1/2/3/4 residents: The resident is expected to see promptly all patients on whom general medicine or subspecialty medicine consultations are requested. The chart should be reviewed to determine pertinent past history and investigations. The patient should be interviewed and a physical examination performed. The resident should assemble pertinent laboratory data, other diagnostic studies, and organize a concise presentation of the problem to the attending physician on the consultation service. It is the resident's further responsibility to ensure that recommendations are transmitted accurately with a well-organized chart note. The note should detail the reasons for the suggested studies or changes in management and not be a list of directives to the ward team or to the residents on another service. Personal or telephone communication to the primary team will vastly improve the response to the consultation and is common courtesy. Internal Medicine residents on consultation services write orders for patients who they are seeing if the primary team so desires, except if the primary team is an internal medicine teaching team in which case the primary team's residents write all orders (see above). Daily follow-up visits to determine results of studies suggested or responses to therapeutic changes are also necessary, as are daily notes.

If a General Medicine consult is needed after 4:00 P.M. on a weekday or on the weekend, it is the responsibility of the resident on call. The patient should be evaluated as above and the Internal Medicine attending on call should be contacted to discuss the patient and determine appropriate recommendations. The resident on call is also

responsible for answering nurse calls related to medical issues for patients being followed by the General Medicine consult team, for evaluating the patient if necessary, and for placing orders as needed. *This policy only applies to patients being followed by the Gen Med consult team or new Gen Med consults.* If a subspecialty medicine consultation is needed, the resident should notify the appropriate consultative resident, fellow or attending according to the call schedule.

**ATTENDING PHYSICIANS:** The attending physician must look upon a consultation as not only an encounter to advise the physician or group responsible for the patient regarding the patient's diagnosis, additional studies that might be needed, or changes in therapy, but also as an education exchange for the resident on his/her service and the team requesting the consult. When possible, the attending physician should speak with the residents on the team that initiated the consultation request and express an opinion and the reasons for suggestions for study or changes in treatment. A thorough initial consultation note must be written. The attending physician must see the patient as is appropriate with subsequent documentation by a chart note.

### **Ambulatory Services and the Ambulatory Block**

**Continuity Clinic:** All Internal Medicine residents will be assigned to a continuity clinic at the UAMS Out-Patient Center or the VA Primary Care Clinic.

#### **Contact Person:**

- UAMS clinic: Dr. Alice Alexander
- VA clinic: Dr. Shagufta Siddiqui

One of the most important skills to be obtained during your residency in Internal Medicine is the efficient and effective handling of outpatient encounters. Resident Clinic is structured to offer you a varied clinical experience in acute and chronic outpatient disorders in the adult.

- Residents are expected to be on time to clinic. Our schedule is designed to eliminate conflicts between outpatient and inpatient duties, so you are free to focus on your clinic duties during your clinic sessions.
- Residents are expected to work in a timely and efficient manner in clinic. (i.e., if a resident sends a patient from clinic for a CXR or ECG, he/she should still continue seeing other patients while awaiting the results).
- Clinic swaps are strictly limited.

#### **Goals:**

- Evaluate acute health concerns in an ambulatory setting, including appropriately triaging patients to the emergency department or hospital;
- Deliver high quality, evidence based care for chronic diseases;
- Deliver high quality preventative health care;
- Coordinate care with other health professionals such as specialists, inpatient physician teams, nurses, and other non-physician professionals;

- Use an electronic health record (EPIC/CPRS) to care for a panel of patients.

### **Scheduling Residents:**

- **House Staff Schedules:** In accordance with requirements of the Internal Medicine RRC, all residents will have  $\geq 130$  clinic sessions over 3 years. Internal Medicine residents will be assigned their ambulatory experience at either the University Hospital or Veterans Administration Hospital. Medicine/Pediatrics residents will have clinics at both University Hospital and Arkansas Children's Hospital.

- **Categorical internal medicine PGY1s PGY2s and PGY3s** will have clinic one week out of every five. During your "ambulatory week", you will have five, half-day sessions of continuity clinic. These continuity clinic sessions will be on the same half-days every time you have an ambulatory week. PGY1s are permitted 2 vacation weeks during ambulatory weeks; PGY2/3 residents cannot take vacation during an ambulatory week.

- **Med/Peds residents** will have six ambulatory weeks during the academic year. These weeks are predetermined and are designed to fall during elective rotations. You are responsible for notifying the appropriate persons on your elective rotation if you have a clinic week assigned in the middle of an elective rotation. M-P residents will have four internal medicine and four pediatric sessions during a clinic week and will join IM residents for ambulatory didactics (see below). M-P residents may also have an "extra" clinic day on a Friday if there are more than 9 weeks between scheduled clinic weeks.

- **Med/Peds interns** will have a full "clinic day" consisting of one half-day in medicine clinic and one half-day in pediatrics clinic. This clinic day will occur either every other week or weekly depending on the rotation you are assigned. In the event that a night shift must be scheduled the day before your clinic day (i.e., peds, ER nights), the pediatric chiefs will notify the appropriate medicine and pediatrics people regarding the need to cancel a clinic. Clinics will be canceled for M/P interns and residents on the following rotations: CCU, MICU, NICU, ICN, PICU, and Nursery.

- It is ultimately the resident's responsibility to make sure that his/her clinic patients are rescheduled when he/she has a clinic day change or cancellation. Clinic schedules are easily viewable in advance through CPRS or EPIC. If you have clinic patients scheduled on a day when you will not be there, notify the Chief Residents and the appropriate clinic medical director.

- Trades of clinic days are strictly limited (clinic trades impair the ability to develop and maintain patient care continuity). See policy on Page 25.

- The electronic chart is available at UAMS, VAH & ACH. It is **your responsibility** for follow-up of laboratory or imaging tests that you have ordered while in clinic. If you order a test, **you are responsible** to take appropriate action. If you need assistance in making a further plan, contact the attending who saw the patient with you in clinic.

- The electronic medical record is designed to allow timely communication between you and the clinic staff, even during times when you are not in clinic. In

fact, it is an internal medicine program requirement that residents retain responsibility for their panel of continuity patients between clinic visits. You are expected to check your EPIC In-basket at least three times a week and to reply to all documents in a timely manner. Access to EPIC is available off-campus by going through UAMS MyDesk (mydesk.uams.edu).

- At the VA Hospital, limited ancillary services are available after 17:00, and our check-out clerk will usually not be available after 16:30. Ensure that any patient who checks out after 16:00 has appropriate follow-up instructions incorporated in the clinic note. The clinic nurse and clerk should be named as co-signers of the note to make sure they see and act on your instructions the next business day.

- All patients must be checked out to an attending physician and this must be documented in your note.

### **Location:**

- The UAMS clinic is located in the outpatient building on the second floor. The workroom is equipped with several computer terminals and each patient room has its own computer terminal for convenient access to facilitate efficient patient care.

- The VA clinics for General Internal Medicine are located at Fort Roots in North Little Rock.

### **Scheduling Patients:**

- The clinics will operate as a group practice. You will be assigned a panel of patients but if one of your colleagues is not in clinic or if we have a walk-in to the clinic, other patients may be assigned to you. At the beginning of every clinic session all clinic slots convert to same-day appointments – you must not leave early because you may have a patient added to your schedule at any time.

- The outpatient scheduling center at UAMS or the VAH clinic clerks schedule all patients. You should make a note of when you want your patient to return to your clinic and at UAMS place an order for this in EPIC. At the VA, the clerks will schedule patients according to the time frame that is in your note.

- Overbooks are occasionally necessary depending on patient care needs and clinic staffing. The involved resident or the clinic attending must approve overbooked patients.

### **Educational Activities:**

- The program has subscribed to the Johns Hopkins online ambulatory curriculum. The online modules are available through [www.hopkinsilc.org](http://www.hopkinsilc.org) – we will provide you more information about logging in and which modules you will need to do.

- All categorical internal medicine residents have didactic sessions, including QI, during each ambulatory week on Tuesday and Wednesday mornings at 8:30 in the Abernathy classroom. Attendance is required for both UAMS and VA clinic residents. Some of the didactic time will be spent in the Simulation Center. If you must be absent, you must notify Dr. Alexander. There

will be assigned pre-readings before the didactic sessions that will be emailed to your group.

- Unexcused absences from didactic sessions and/or failure to complete assigned educational modules may result in assignment of additional clinical duties or other consequences as determined by the program director and Chief Residents.

### **Patients:**

- Your patient load will increase gradually as you advance in your skills. PGY1 residents will initially be assigned 3-4 patients per clinic day and this will increase to 5 patients by the end of the first year. PGY2 and PGY3 residents will be assigned 5-7 patients per clinic day. ***You are required to be in clinic even if you do not have patients scheduled for a particular day. Remember this is a Group practice. You may be assigned other patients.***

### **Medical Record and Documentation:**

- Every patient encounter must be documented in the patient's medical record.
- The VA uses a computerized record system called CPRS. You will receive training in the use of this system prior to your first patient encounter. If this system is nonfunctional, hardcopy backup procedures will be used. At the VA Hospital, electronic encounter forms must be completed on every patient in CPRS.
- UAMS uses a computerized record system called EPIC. You will also receive training for this prior to your clinic experience. Clinic notes must be complete within 48 hours after the end of the encounter.

### **Policy for UAMS Resident Clinic Changes that Occur within 90 Days of the Scheduled Clinic**

- The only acceptable reason for a resident to not be present as scheduled in his/her clinic is the occurrence of a *true emergency* (e.g. accident, illness, birth of a child, illness/death of a family member).
- When such an emergency occurs and the resident believes that he cannot be present in clinic as scheduled, he must immediately contact a Chief Resident who will then find a suitable substitute from the pool of residents on Jeopardy, preferably a resident who is on the same clinic team as the resident for whom he is going to cover.
- Under NO circumstances should a resident directly contact another resident to ask for clinic coverage in the form of a trade or favor unless this has been approved by the Chief Residents or clinic medical director.
- A resident who cannot be in clinic as scheduled due to an emergency pays back the resident who was "jeopardized" to cover for him. Payback is preferred to be in the form of a short call, not by covering the other's clinic because clinic-for-clinic swaps or trades hurt continuity of care twice.
- Because clinics may be cancelled during vacations (for M/P residents and for PGY1s who must take a vacation during an ambulatory week), it is essential

that we have advance notice about any changes in vacation time. Any change in vacation must be communicated to the House Staff Office more than 90 days beforehand and the appropriate form must be completed. This allows sufficient time for the Appointment Center to reschedule the patients.

- Any anticipated absences such as a late-notice vacation change or educational leave should be communicated to the clinic medical director as soon as possible so that this change can be accommodated. Depending on the time frame a cancellation or coverage by a colleague (see below) may be requested. Late cancellations for any reasons are required to have approval by the department chairman, Dr. Marsh, and he will only approve these on a very limited basis.

- If a resident needs to be absent from clinic for other University or educational business that is not scheduled >30 days ahead of time (for example, a project meeting, committee meeting, etc.), it is acceptable to ask a colleague to cover his or her clinic; this coverage arrangement must be approved by the Chief Residents and appropriate clinic medical director. Payback is expected.

### **Subspecialty clinics and other responsibilities during the ambulatory week:**

For categorical IM residents, the ambulatory week includes 5 half-days of continuity clinic either at the VA or UAMS as described above, 2 half-days of subspecialty clinics, 2 half-days of small group didactics that include use of the Simulation Center, and 1 half-day to work on QI projects. *Attendance at all components of the ambulatory week and participation in QI is mandatory.* The only acceptable reasons to miss any ambulatory week activity are vacation (for interns) and unavoidable situations like illness.

**ATTENDING PHYSICIANS:** The attending physician must look upon the ambulatory clinic visit as not only an encounter to provide primary or tertiary specialty care to a patient, but also as an education exchange for the resident on his or her service. When possible, the attending physician should speak with the residents on the team that initiated the ambulatory clinic request and express an opinion and the reasons for suggestions for study or changes in treatment. A thorough initial clinic note must be written. The attending physician must see the patient as is appropriate with subsequent documentation by a clinic note.

## Policy: Transfer Protocol for Handoffs

### **Transfers and Handoffs**

Patient handoffs on the inpatient services are performed face-to-face (or less desirably, by phone) and an electronic and/or type-written document is provided by the transferring team/physician to the receiving physician/team at the time of the handoff. *Careful, thorough, verbally communicated checkouts are required for all transitions of care.* The attending physician on the team is encouraged, but not required, to participate in handoffs to the call or float team and the covering team is strongly encouraged to call the patient's attending physician for concerns, questions and critical events,

Transfer protocol:

*From ICU to 'floor' [or 'floor' to ICU]:* ICU intern or resident will complete transfer orders and a transfer note in the record. The ICU intern and the ICU resident must personally speak with their floor counterparts to provide a handoff prior to the transfer. It is critical that communication occurs at every level to minimize the chance of "losing" a patient. Floor nurse will page the floor resident when patient arrives on the floor. (For the preceding 4 sentences, substitute "floor" for "ICU" and "ICU" for "floor" for patients being transferred from the floor to the ICU). The receiving resident or intern will complete an 'accept note' in the medical record noting the status of the patient and receiving team.

*Transfer between services [e.g. Surgery to Medicine, one medicine team to another]:* The transferring resident is responsible for contacting the receiving resident for handoff as described above. *Furthermore, inter-service transfers require attending-to-attending communication.* Neither the transferring resident nor the accepting resident should act as a go-between for the attendings. The transferring resident must write a transfer note and transfer orders. Receiving team must complete an accept note in the record after personal assessment of the patient.

Handoff education is and will continue to be provided on at least an annual basis as a component of the educational conference series; and issues related to this topic will be reviewed routinely at Systems and M&M conferences.

### **Transfer and Educational Material Related to Handoffs/Transfers**

The Chief Residents give Powerpoint presentation at the beginning of each year to all incoming interns which includes cross-cover, check out procedures, and communication. This information is also reviewed with upper level residents at the beginning of each year.