Internal Medicine House Staff Handbook and Policies
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UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
DEPARTMENT OF INTERNAL MEDICINE
HOUSE STAFF GUIDELINES AND POLICIES
2016-2017

INTRODUCTION:
We would like to welcome you to Little Rock and to our Internal Medicine program at the University of Arkansas for Medical Sciences. Our mission is to provide you with excellent education, and we are committed to helping you become a great internist. In this new academic year, our program will use a block schedule (4 weeks traditional rotation + 1 week ambulatory) for all years of training.

WARD SERVICES: University Hospital

There are five teams comprising the teaching service (2 general medicine and 3 subspecialty teams). There are also four direct care hospitalist teams (3C, 3D, 3E, and 3F) and one hematology/oncology team to which residents are not assigned.

Team 1/CCU:	CARDIOLOGY
Team 2A:	HEMATOLOGY/ONCOLOGY
Team 3A and 3B:	GENERAL MEDICINE
Team 6:	ABERNATHY INFECTIOUS DISEASES

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 3 interns. These are the main teaching teams for medical students. These teams cap at 16 patients. Two of the three interns on 3A and 3B rotate on a night float system throughout the month. These interns complete approximately 12 night shifts per month, in 2 blocks of 6 nights.
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.

ADMISSIONS: University Hospital

All 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 resident on call for the day 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 will be assigned to the Abernathy ID Team (Team 6).
6. Geriatrics patients followed by the Reynolds Center should be admitted to a non-teaching general medicine service (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 4 p.m., admissions should be assigned in a round-robin fashion with a 2:2 ratio with the non-teaching teams (including cardiology 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.

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 interns rotating on nights from 3A and 3B. 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 call team is responsible for all admissions (ED and direct).

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.
- 16:00-19:00: MICU Resident on call is responsible for all admissions and transfers from the floor.
- 19:00-07:00: 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 2:1 ratio of transfers to the non-teaching teams. Patients who were previously on a team should be transferred back to that respective team.

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.

WARD SERVICES: VA Hospital

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.

Team 1:	GENERAL MEDICINE
Team 2:	GENERAL MEDICINE
Team 3:	GENERAL MEDICINE
Team 7/CCU:	CARDIOLOGY

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 12 patients.

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.

ADMISSIONS: VA Hospital

General Medicine admissions:
The direct-care hospitalists will be responsible for assigning all admissions to the general medicine service including admissions from the ED, clinics, NLR VA, and other facilities.

1) The direct care hospitalists will be responsible for all admissions to the General Medicine service from 07:00 to 07:00.
2) From 07:00-16:00, the direct care hospitalist will contact the on call resident with admissions. All medicine admissions between 07:00-16:00 will be assigned to the medicine teaching services. The on call resident will assign admissions to medicine teams in a round-robin fashion. 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.
3) From 16:00-19:00, the short call resident and two interns will be responsible for all admissions assigned to the teaching teams. Once a teaching team reaches a cap of 12 patients, this team falls out of the round-robin

rotation. Once all General Medicine teaching teams are capped, all Gen Med admissions are the responsibility of the direct-care hospitalists.

4) From 16:00 – 19:00, all admissions will be assigned in a 1:1 ratio between medicine teaching services and direct care hospitalist teams.
5) The direct-care teams will accept all admissions with low educational value including acute alcohol intoxication, post procedure observation, patients with primarily social issues, etc.

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

DUTY HOURS:

- When averaged over a 4-week period, residents must not spend more than 80 hours per week in patient care duties, inclusive of all in-house, on-call activities, and all moonlighting, and residents must have at least 1 day out of 7 free of patient care duties averaged over a 4-week period.
- PGY-1 residents must not have patient care duties more than 16 hours at a time and should have 10 hours, but must have 8 hours, off between duty periods.
- PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty (plus 4 additional hours to assure effective transitions in care) and should have 10 hours, but must have 8 hours, off between duty periods. 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.

Tips for entering duty hours in New Innovations:

1) Post Call
    a) Any transition of care and educational activities done after 24 continuous hours of in-house duty must be logged with the correct duty type ("Transition of Care," "Hand-offs," "Conference," or "Educational"). Hours logged past 24 as any other duty type, will create a duty hour violation, even if the resident was engaged in appropriate activities.
    b) The "Justifications" feature in New Innovations should only be used for those times when a resident stays past 24 hours "on their own initiative" for the reasons outlined in the ACGME Common Program Requirements [VI.G.4.b). (3)-*In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family*], not when they have stayed past 24 hours to perform transition of care activities. If transition of care activities are logged correctly, these hours will not cause a violation; thus, no need for a justification.
2) Day Off
    a) It is not necessary to log "Days Off". New Innovations will recognize any period of 24 hours without any time logged as the 24-hour period free of duty that the ACGME requires. This does not apply to vacation or other leave time. Residents can continue to log leave time in the designated area.

Other Issues

a) Residents need to avoid leaving short periods of time during their day without any hours logged (meal break, time between call and conference, drive time between sites, etc.). These gaps cause short-break violations (less than 8-10 hours off between duty assignments). Once a resident reports for duty and until they get another 8-10 (or more) hours off, his or her hours should count toward the 24 hours maximum of continuous duty.
b) When a resident is scheduled on a rotation that "belongs" to another program, he or she needs to use that program's duty types. (When residents log hours while on another program's rotation, the department option on the duty hour log screen will default to the department that owns the rotation.) It will not check for violations if a resident records a duty type that is not active in the other program's basic configuration.

COMMUNICATION: with attendings

For both education and optimal patient care, the House Staff must communicate freely with attendings on all services. If there are questions or problems, the resident or intern should feel free to contact the subspecialty service at any time. Attending physicians want and need to be contacted regarding patients; if there are problems, contact the Chief Resident, Residency Program Director or Department Chairman. Residents must call the attending of record whenever a patient dies or when a change in the patient's clinical status necessitates transfer to another team or a higher level of care (i.e. transfer from the floor to the MICU or CCU).

COMMUNICATION: with residents

Communication between residents is imperative for safe and successful patient care.

- Team Residents/Interns to On-Call Residents/Interns: There is a mandatory checkout list to be given to the on-call team. This list is to be up-to-date and must include all the current patients and all the expected patients from outside hospital admissions, clinic admissions, or transfers from different services. Verbal and face-to-face checkout is required.
- On-Call Residents/Interns to Night Float Residents/Interns to Team Residents/Interns: Communication between the On-call Team and the Night Float Team must be efficient as to ensure patient continuity of care. Night Float Resident to Team Resident communication must happen in a timely manner first thing in the morning so that the Night Float Resident can leave on time. Night Float Interns to Team Interns must communicate essential events overnight so that the team will be aware of any potential problems.
- Transferring Patients: Communication between residents when a patient is transferred from one service to another is essential. It is the responsibility of the Transferring Team Resident to contact the Accepting Team Resident any time a patient is transferred between services. As a secondary safeguard, the transferring intern will also contact the accepting intern. A transfer note must accompany the patient to the accepting team and must include the accepting team's attending physician and resident.
- Accepting Patients: An accept note is required for all patients accepted to a team. If the patient is accepted and transferred during the day, one of the accepting team members must complete the accept note. If the transfer occurs during on-call hours, the patient's name must be added to the list of new admissions for the evening so that this patient is passed off to the team the next morning. If an on-call intern accepts a patient transfer and writes the accept note, the intern must communicate with the on-call resident so that the accepting patient can be placed on the list of admissions.
- Off-Service Notes: At the end of each rotation, an off-service note with a summary of patient's hospital course thus far must be written to help facilitate transfer of care to the oncoming team. This may be written in EPIC as a progress note, or alternatively written in EPIC under the hospital course section of the Discharge Summary to which the team can refer.

COMMUNICATION: with nursing staff or other ancillary staff

- When a resident is contacted in error about an IM admission or a transfer, he or she should take the time to find out who does need to be called. We do not want the Emergency Department or the floor staff to call multiple persons with each person denying responsibilities. Our call schedule can be intimidating and we should be willing to find the appropriate resident or intern.
- If a resident has an issue with the nursing staff or other ancillary staff, the resident should document what the event was, who was involved and a brief description of what happened. This should then be taken to the Chief Resident as soon as possible. If the resident needs immediate assistance, the Chief Resident is to be called.
- Professionalism is one of the key competencies to master while in residency. Part of professionalism is being able to communicate effectively and resolve conflicts in patient care.

COMMUNICATION: supervising residents and interns on call

- Every decision made by an intern about a deteriorating patient must be discussed with the supervising resident on short call, overnight call or float rotations. This resident can be a PGY-2 or 3 who is on call with an intern. This would include telephone calls and person-to-person communication to show ECG tracings, CXRs, or other results. Documentation of the discussion in the patient record is required.

- In addition, interns must call for any patient, even if not in a deteriorating status, when there is any question or discomfort about the diagnosis or management of a patient.
- Subspecialty fellows and attending physicians must be called when there is an unexpected and dramatic change in the condition of their patient (including death) or if there is a question regarding the diagnosis or management of a patient, or if there is a change in level of care.
- Any patient accepted to the floor by the intern from the MICU/CCU service must be communicated to the supervising resident so that this patient may be placed on the admission list to ensure check-out to the accepting team the following morning.

CHECK-OUTS & HAND-OFFS: standard operating procedure for Internal Medicine services:

All teams must maintain an updated version of their team list. The list should be updated at a minimum in the morning and again at the end of the work day. The list must be stored in a protected location on the hospital server's hard drive, and printed copies of the list should be safeguarded closely and discarded in the appropriate way (into locked HIPAA compliant shred bins) since they contain protected health information. Check-out lists should include at a minimum the patient's name, location, age, brief history/reason for admission, working diagnosis, code status, and things to check. If there are other important issues (i.e. patient is a Jehovah's witness and will not accept blood products or the family is not to be told of the patient's HIV status, etc.), they should be included on the check-out list. Lists should also include contact information for the responsible attending. Check-outs must occur face-to-face between residents. Telephone check-out is not acceptable. Every team should check-out to the short-call resident and interns, who will then check-out to the night float resident and interns. Each House Staff should check-out using an updated, printed copy of their team list. It is the outgoing resident's responsibility to contact the on-call resident for check-out. If a resident does not check-out to the on-call team, the Chief Resident should be notified.

Check-out should include a brief verbal description of each patient and the major reason(s) why they are currently in the hospital. Any significant events over the past 24 hours should be mentioned as well as any potentially anticipated events. If there are test results pending that are on your "to check" list, you should also include what to do with the results (i.e., CBC at 19:00, if hemoglobin less than 7.0 give 1 unit of packed RBC's).

In general, you should NOT check-out pending EKGs, procedures, or post-procedure imaging. Lab results, consults, and radiology exams that could potentially change a patient's management can be checked out in most cases. If a patient arrives while you are still on duty, the responsibility for admitting that patient is yours (although it is acceptable to ask the oncoming resident to help with admissions so that you can leave the hospital at a reasonable time in order to avoid violating duty hour regulations).

CONSULTATIONS

The Department of Medicine receives many consultation requests, both for subspecialty as well as general medicine evaluations. The department views these consultations as an important part of resident education; they should be seen quickly and diplomatically as we hope other departments will do for us. Several points concerning consultations deserve emphasis:

- Subspecialty consultations will usually be evaluated by the resident and/or intern on the subspecialty consult service first and then presented to the subspecialty attending. An exception to this generalization might be the private patient of a faculty member. In that case, the faculty member may care for the patient initially and bypass the subspecialty house staff.
- A General Internal Medicine consult service is established at the VA Hospital. This team will be staffed by the hospitalist team attending. This consult service will be staffed during weekday hours from 8:00-16:00.

- General Internal Medicine consultations at UAMS will be the responsibility of the resident or intern and faculty assigned to the General Internal Medicine Consultation Service. If the resident on the consultation service cannot see the patient in a timely manner, it is the responsibility of that resident to contact the Chief Resident to discuss the problem. The Chief Resident will see the patient or ask a subspecialty resident to see the patient. After 16:00 M-F and on weekends and holidays, the resident on call will provide coverage for IM consults at UAMS and contact the faculty who is on call for General Internal Medicine. For the VA hospital, the non-teaching hospitalists will be staffing those consults.
- Night float resident at UAMS will notify the appropriate consultation service the next morning about any patient seen at night. This communication is important to ensure follow-up.

DISCHARGES: University Hospital and VA Hospital

In order to expedite patient admissions to the hospital, early discharges are mandatory. Discharge orders on patients known to be ready for discharge should be entered into the computer order system prior to noon. If there are questions about whether or not to discharge a patient, the attending should be called for direction. Discharge summaries at the University Hospital and the VA Hospital are the responsibility of the resident or the intern on the team. Discharge summaries are due 7 days after the date of discharge. If not completed after 7 days, disciplinary actions including, but not limited to, monetary fines may be taken at UAMS. At the VA, discharge summaries are due within 24 hours of the discharge date.

TRANSFERS: University Hospital and VA Hospital

The general policy of the Internal Medicine services is that if an outside hospital physician calls wishing to transfer a patient to UAMS, we accept the patient unless we cannot offer services different than the transferring hospital. It is not appropriate for us to accept a transfer from another hospital simply because the patient cannot pay. The University Hospital has instituted an administrative transfer team to evaluate the financial status and obtain a transfer-back agreement. The UAMS transfer team will then determine further eligibility for transfer and initiate the timing of the transfer. During the M-F working hours of 08:00-16:00, the Chief Resident will be contacted for general medicine transfer(s) and assigning them to teams. After 16:00, weekends, and holidays, the on-call general medicine attending or subspecialty attending on call is responsible for accepting outside hospital transfers. The assigned team shall be notified of the expected patient by the accepting Chief Resident or attending.

If a patient is in the emergency department in the outside hospital and the physician wants to transfer the patient, the patient may be accepted directly if stable and an initial workup is done. If the patient is on a floor, he/ she must be accepted to the same level bed as the outside facility. Therefore, if patients are on telemetry, they come to a telemetry bed; if they are in the outside facility's stepdown unit, they will be accepted to our ICU. Patients cannot be accepted directly to stepdown from transferring facilities.

Residents DO NOT accept MICU or CCU patients at either hospital and these must go through the direct-care hospitalists for the VA hospital who will communicate with the on-call pulmonary/critical care fellow for MICU or the on-call cardiology fellow for CCU transfer. Patients must be out of the unit for 24 hours prior to being transferred to the floor at UAMS. This can be negotiated at the VA. We do not have the right to refuse transfer to the VA unless the patient is unstable for transfer. The direct-care hospitalist accepts patients at the VA and recommends level of care and will contact bed control and leave the appropriate documentation in CPRS. If no beds are available, the patient will be accepted "pending bed availability".

CONFERENCES

MONDAY:

- 12:00 Core Curriculum
- 1:00 Board Review

TUESDAY:

- 12:00 Medicine-Pathology Conference
- 12:00 Systems Conference: third Tuesday of every month
- 1:00 Afternoon Case Discussion

WEDNESDAY:

- 12:00 Core Curriculum
- 1:00 Intern Report

THURSDAY:

- 07:30-08:30 on the fourth Thursday of every month: Morbidity and Mortality
- 12:00 Internal Medicine Grand Rounds
- 1:00 Afternoon Case Discussion

FRIDAY:

- 12:00 Resident Presentation / Journal Club
- 1:00 Afternoon Case discussion

Thursday M&M Conference:

All interns and residents working at UAMS and VA are required to attend. The conference is held the 4th Thursday of the month except for November and December, when it is held the 3rd Thursday of the month. Residents must not schedule days off on M&M days. No medical students or off-service interns are to attend this conference. ACD is cancelled at both hospitals on M&M conference days. All cases (deaths, complications, or selected cases requested by the Chairman, Chiefs, Faculty, or Residents) are reviewed by the Chief Residents and Dr. Rutlen. Cases are selected for presentation based upon learning interest and/or Department of Medicine quality issues. Cases involving quality issues relevant to other departments may also be reviewed. Cases selected will be assigned for presentation to the most senior resident involved in the care of the patient. One or more VA cases will also be selected for presentation and discussion. All participants understand that medical information regarding patient health is personal and confidential and are committed to protecting the confidentiality of patient medical information. This Conference is understood by all participants to be for the improvement in the quality of care for our patients. It is not a venue for placing blame or finger-pointing. Such activities will not be tolerated.

INTERN REPORT

Interns working on wards at UAMS & VA present Wednesday at 1:00 PM in the Ebert Library (S307) at UAMS.

- Attendance is ***mandatory*** unless it is a day off.
- Ward residents and interns on consult services are encouraged, but not required, to attend intern report.

AFTERNOON CASE DISCUSSION (ACD)

ACD is presented by an upper level—regardless of service—and is held Tuesday, Thursday and Friday at 1:00 PM. On Tuesdays we use VA room 6B-117. On Thursday and Friday we use the Ebert Library (S307).

- Attendance is ***mandatory*** for ward residents unless it is a day off.
- Ward interns and consult service residents and interns are encouraged, but not required, to attend ACD.

BOARD REVIEW

Board review sessions are held Monday at 1:00 PM in the Ebert Library. Although geared primarily for PGY-3 residents, all are encouraged to attend as we go through MKSAP and UWorld questions.

A final note:
The National Residency Review Committee-Internal Medicine requires attendance by residents at some conferences deemed to be mandatory. Our Education Cabinet considers Core Curriculum Conferences and Grand Rounds to be mandatory and requires 80% attendance.

IN-TRAINING EXAMINATION

All PGY-1 and PGY-2 residents must take the ACP's In-Training exam (ITE). For PGY-3 residents the test is optional, but only if they have scored above the 50th percentile as a PGY-1 or -2. The results are used to identify areas of strength, areas for improvement, and to help predict success or failure on the American Board of Internal Medicine Certifying Exam (ABIM-CE). Published data indicates that PGY-2 residents whose national percentile on the ITE is above the 30th are very likely to pass the ABIM-CE. If a resident scores below the 30th percentile on the ITE, he/she will not qualify for a research rotation, and further remediation will be decided as directed by the Program Director. The Department assumes the cost of the ITE for all 3 years.

ADDRESSING RESIDENT CONCERNS IN INTERNAL MEDICINE

At times, various issues resulting from miscommunication, stress, or inappropriate behavior may arise. In compliance with the UAMS College of Medicine GME Committee Policy on Addressing Concerns in a Confidential and Protected Manner, the resident should follow these guidelines to raise and resolve issues of concern in a confidential and protected manner:

Approach:

If a resident has an area of concern that should be addressed, the following approach is recommended:

- 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.
- If the above discussion does not resolve the concern, the resident should meet with the Program Director or his designee.
- If the issue cannot be resolved by the Program Director, the resident should contact at least two members of the Resident Council (contact list found on the GME webpage) and/or the Associate Dean for Graduate Medical Education to discuss the issue confidentially. Members of the Resident Council can meet with the resident and offer advice on how to resolve or handle the problem and decide whether further steps are necessary. Based on the discussion and advice of this meeting, the resident may resolve the problem, and no further action is necessary.
- If the resident desires further discussion, or for serious issues for which confidentiality is of the utmost importance, the resident may seek assistance directly from his Chairman and/or the Associate Dean for GME.

JEOPARDY

In the absence of a resident or intern who is scheduled on ward/ICU rotations for reasons of unforeseen illness or death of a family member, jeopardy is available for coverage. The jeopardy schedule is comprised of residents on consult rotations. Each resident is assigned approximately a one week block of "call" during which he/she will be available for emergencies. There are two residents and one intern assigned on call for jeopardy for each day. Either House Staff can be called depending on need. The Jeopardy system will not be used for non-essential service coverage such as subspecialty electives. It is also not used for scheduled absences. If a resident or intern must be away from the hospital other than vacation time, he or she must arrange his or her own coverage. (This does not apply

to clinic coverage. Residents are not permitted to make their own arrangements to cover for each other in clinic). The Residency Medicine Office and Chief Resident must be notified of all changes.

- Jeopardy call will be assigned in 1-week blocks to 2nd and 3rd year residents on consult rotations.
- There will be two residents assigned per week to jeopardy.
- There will be one intern assigned per week to jeopardy.
- If the resident assigned to jeopardy trades out of his/her consult rotation for another (i.e., wards), it is his/her responsibility to find a jeopardy replacement. If no arrangements are made, the resident trading into that consult month will be required to cover that jeopardy call.
- If a resident uses jeopardy improperly, he/she will be expected to pay time back into the system (i.e., a day for a day). Legitimate use for jeopardy is illness or emergency, taking an extra day of vacation is not.
- If House Staff utilizes jeopardy for illness, then he or she will be expected to see a physician. If a physician is not available, House Staff will be seen in medicine clinic at UAMS.
- Excuses: There are very few legitimate excuses for missing a jeopardy call. It is your responsibility to check the schedule monthly to assure you are not on call and make prior arrangements if you are unable to cover. Jeopardy schedules for the upcoming month should be made available nearly a month prior for residents to review and plan.

LEAVE FOR RESIDENTS

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, 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.

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.

- PGY1: 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.
- PGY2 and PGY3: 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, 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.

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:

Residents may request leave of one (1) to three (3) days due to death of a member of his/her immediate family. Requests for this leave or extension of this leave beyond three days must be approved by the Program Director.

MOONLIGHTING

The institutional polices regarding moonlighting can be found here. http://medicine.uams.edu/current-residents/gme-committee-policies

SCHEDULE CHANGES

All schedule change requests must be submitted via email to the Chief Residents.

PROCEDURE DOCUMENTATION

For certification in Internal Medicine, ABIM has identified a limited set of procedures in which it expects all candidates to be competent with regard to their knowledge and understanding. Upon completion of your residency it will be essential for you to have a log of the procedures you have performed to ensure technical competence and in obtaining hospital privileges. Procedures include: abdominal paracentesis, advanced cardiac life support, arterial line placement, arthrocentesis, central venous line placement, drawing venous blood, drawing arterial blood, incision and drainage of an abscess, lumbar puncture, nasogastric intubation, pap smear and endocervical culture, placing a peripheral venous line, pulmonary artery catheter placement, and thoracentesis. After you have done a given procedure several times, you no longer need a supervisor's approval but you should continue to record the procedure.

All residents (except preliminary interns) are to enter procedures in New Innovations, the same program used for completion of evaluations. These procedures are to be entered semi-annually so that an updated list will be available during faculty advisor meetings.

To enter procedures go to the website: https://www.new-innov.com/login/
Institution's Login: UAMS (all caps)
Username: first initial and last name (no space in between and in lower case)
Password: same as username (unless you changed it when doing evaluations)
Click on Logger, click on Procedures

RESIDENT TEACHING ROLE

Your choice of a University Hospital for training in Internal Medicine indicates your desire for active supervision and teaching during your training. Your choice also implies a commitment to providing supervision and teaching to those less experienced than you, and we expect this of you. Residents play a vital role in the instruction of medical students--in ward rounds, informal discussions, scheduled ward conferences, and by example. We believe your teaching responsibilities are an important part of your training. There is no better way to insure your understanding of a subject than to prepare to teach others what you know of it.

The ward resident has the potential for a major and lasting impression on the junior and senior students. He/she provides the first model of a clinician and he/she can be certain that the student will emulate many of his/her traits. To set an example of a hurried, sloppy approach to a patient's problem or a rude, inconsiderate attitude toward a sick patient is intolerable.

The specific duties of the resident to the junior clerks and the senior student acting interns on the service are:

- He/She should assign the students patients as they are admitted. Usually this is done in rotation, but a strict rotation schedule should not be allowed to interfere with a balanced patient experience for a student. Patients should be assigned as soon as possible after their admission. This is particularly important in patients who are acutely ill. For example, the major teaching value of a patient with gastrointestinal bleeding, acute pulmonary edema, or sepsis, resides in the first few hours of his hospitalization. Students should follow a

limited number of patients – they should be able to focus on understanding the patient's disease process and not be overloaded with a large volume of patients.

- The resident should conduct daily teaching rounds for the students. Attendance at these rounds may be limited to the student, or they may be combined with the interns for afternoon "work rounds". Rounds with the students provide an opportunity to find out if they understand the changes and developments in their patient's course and treatment, and give them a chance to ask questions concerning therapy, laboratory tests, etc. These discussions of immediate clinical problems in patients that students know and have examined are of tremendous importance in their clinical training. Their value is not limited to the student; explaining an illness and the reason for a proposed or established therapeutic regimen aids the resident and intern in crystallizing their concepts of the patient and his disease. We look on the resident's rounds with the students as a major part of the student teaching program and will insist that you give it the time and effort that it deserves.
- The resident should select patients for the senior acting interns to work up and to present to the attending physician on rounds. In choosing patients from the wards, a primary consideration should be given to the teaching value of the patient chosen. The resident should not feel bound to adhere to a strict rotation of students. It is the resident's responsibility to be certain that students grasp the fundamental nature of the patient's problem and to advise him or her in their reading and preparation for the presentation. Finally, he should see that diagnostic studies are not scheduled that would take the patient to be discussed away from the ward.

EVALUATIONS

Resident and Intern Evaluations (by attendings): At the end of each rotation, attendings submit evaluations of their residents and interns based upon the goals and objectives for the rotation (see Residency Education Clinical Curriculum for details)

Resident Evaluations: At the end of each rotation, the interns submit evaluations of their residents.

Intern Evaluations: At the end of each rotation period, the ward residents submit evaluations of their interns. Residents should provide timely feedback as to the intern's performance throughout the course of the month.

Attending Evaluations (by interns and residents): At the end of each rotation, the interns and residents submit evaluations of their attending. This evaluation is totally anonymous and is used by the department for feedback to the attending.

Continuity Clinic Evaluations: These evaluations are completed by faculty members to give the training program feedback regarding the intern/resident's performance in the continuity clinic.

Multi-Rater Evaluations: Periodically evaluations are completed by non-MD, non-student healthcare professionals to give the training program feedback on the intern's/resident's interpersonal communication and skills and professionalism.

Patient/Family Evaluations: Periodically evaluations are completed by patients and/or family members to give the training program feedback on the intern's/resident's interpersonal communication and skills and professionalism.

Resident Self-Evaluations: These evaluations are requested from interns/residents annually to promote practice-based learning and improvement.

Training Program Evaluations: All residents evaluate the program, the institution, and the hospitals via the ACGME survey each year This is an anonymous survey, the results of which are reviewed during the Annual Program Review with the goal of improving the program.

Student Evaluations: The ward resident will be asked to submit an evaluation on each of his/her students. If you feel that the student is doing unsatisfactory work, you should discuss it with the attending before the middle of the rotation so he/she can notify the student. The student works with the resident every day and the resident should provide constant feedback to the student. This feedback to be most effective should include what the student is doing right as well as what he/she is doing wrong. The performance of the student on the ward rotation counts for 50% of the final grade so this evaluation is a very important one.

End of the Year Evaluations: At the end of each year, the ABIM requests from the Program Director a summative evaluation of each intern/resident.

EXPECTATIONS OF WARD RESIDENTS

Hospital Arrival:

- Arrive no later than 06:30 and contact night float resident for check-out of new admissions and events overnight.
- Work Rounds: The team should run the list and make a plan for the day for each patient before attending rounds. All discharge planning and orders should be placed before noon on day of discharge. If there are any questions by the team about discharges, the team should contact the attending.

Intern Report/ Afternoon Case Discussion:

- Attendance and participation are mandatory except for days off.

Attending Rounds:

- Interns are responsible for presentation of all patients unless assigned to medical student to present.
- The attending rounds are from 08:30-10:30 at UH and 09:00-11:00 at VA.

Noon Conference:

- Mandatory attendance and participation of at least 80%, or extra call may be given.

Afternoon Activities:

- Call consults, complete procedures
- Create accurate, updated check-out list: A comprehensive, yet brief, list should be given to the appropriate resident and intern on call. This document should contain the patients' name, medical record number, room number, diagnosis, brief history, code status, and pending tests that need to be checked. Check-out list must contain a list of all expected patients (from ICU, clinic, or another facility). <u>If resident or intern is off, the remaining members of the team need to check-out to all levels.</u>
- PROCEDURES ARE NOT TO BE 'CHECKED OUT.' If a patient admitted at 15:30 needs an LP, the primary team needs to do this before leaving. Passing this off to the on-call service is both inappropriate and inconsiderate.

Medical Records

- EPIC is available on all computers at UAMS and is both an inpatient and outpatient computerized medical record system.
- The CAVHS facility uses a Computerized Patient Record System (CPRS).
- Residents and faculty must comply with each hospital's requirements for timely and accurate completion of medical records. It is the resident's responsible to check his/her email regularly and respond in word and deed to alerts regarding medical record delinquencies. Failure to complete delinquent records as required could lead to disciplinary measures, including by not limited to: a verbal warning from the Program Director, and a written warning from the Program Director that becomes a permanent part of the resident's file.

Dress Code

- All residents at the VA and UH are expected to be appropriately dressed and well-groomed at all times. This means khakis or dress trousers, shirt & tie for the men, and skirts/pants & blouse or dresses for the women.
- Scrubs are only appropriate in the following circumstances:
    - MICU/CCU Rotations
    - Night Float
    - On-Call
    - Weekends
    - S/P 24 hr call: even if a resident is s/p 24 hour call, he or she is still expected to take the time to make himself/herself look presentable.
- If a resident is found improperly dressed or groomed, he or she will be sent home to change clothes or "clean up", and will be expected to be back in time for rounds that day.

Cross Coverage for Days Off

- Residents should help out the interns on other teams when their colleagues are off.

Policy for Unexplained Absence.

- Residents must notify the residency office and the Chief Residents via the appropriate channels for EVERY absence. To ensure that communication is kept open, we require all final arrangements for absence be EMAILED to ALL the Chief Residents.

RESIDENT 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. Please see the policy for clinic changes on p. 25 for details.

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 ≥ 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 are not permitted to use ambulatory weeks for vacation.
- 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. MP residents will have four internal medicine and four pediatric sessions during a clinic week and will join IM residents for ambulatory didactics (see below). MP 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 MP 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 – 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 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.

DOCUMENTATION:

History and Physical:

The H&P is an essential component of a patient's complete care while on an inpatient service. Both residents and interns will write H&P. If an intern does write the H&P, the resident should follow this with a RAN (resident admit note). The RAN is a brief account of the history and physical and a well outlined assessment and plan. The H&P must include the following elements:

- DATE, TIME, TITLE, PRIMARY CARE PHYSICIAN: should be all listed at the top of the H&P.
- CHIEF COMPLAINT: in patient's own words, the cause of the hospitalization.
- HPI: description of the CC including timeline of the complaint, aggravating/alleviating factors, associated symptoms.
- PMH: listing of all chronic medical conditions and if necessary a timeline of diagnosis.
- PSH: listing of all surgical procedures and if necessary a timeline of procedures.
- MEDS: listing of all current medications.
- ALL: listing of all medical allergies and the reaction from each.
- SOCIAL HISTORY: listing of tobacco/ETOH/IDU status, occupation status, social support status, and any other lifestyle elements that could directly affect patient's health.
- FAMILY HISTORY: listing of all major diagnoses in family members with timeline if necessary.
- REVIEW OF SYSTEMS: 14 system review is required.
- PHYSICAL EXAM
- LAB: listing of significant lab findings.
- IMAGING: listing of significant imaging.
- ASSESSMENT AND PLAN: by system approach so that all elements of patient care are addressed and nothing is overlooked.

Progress Note:

- SOAP note format with brief subjective overview of patient's status, objective overview of PE, laboratory, and imaging studies followed by an assessment and plan by pertinent system outlining a plan for the day.
- Student notes are required to have a resident or attending addendum and signature.

Discharge Summary:

The discharge summary is vital for continuity of patient care once the patient is discharged from the hospital. It should contain the following elements:

- PATIENT'S NAME AND FULL MRN OR SSN
- DATE OF ADMISSION
- DATE OF DISCHARGE
- SERVICE AND ATTENDING PHYSICIAN
- PRIMARY DIAGNOSIS: primary diagnosis which was the cause of the admission
- SECONDARY DIAGNOSIS: any other diagnoses that were addressed while patient was in the hospital
- CONSULTATIONS
- PROCEDURES
- HPI, PMH, PSH, admit MEDS, ALL, SOCIAL, FH (from H&P)
- PE on admission
- LAB on admission: any significant lab findings on admission
- IMAGING on admission: any significant imaging findings on admission
- HOSPITAL COURSE: summary of hospital events
- DISCHARGE MEDICATIONS: absolutely ESSENTIAL that these medication lists are accurate and match the medications you place in the computer for patient discharge.

- DISCHARGE INSTRUCTIONS: list of special instructions including dietary, activity level/return to work, monitoring symptoms at home and when to return to ED with problems, etc.
- DISCHARGE FOLLOW-UP: list of follow up appointments, imaging exams, lab evaluation or any other f/u that is necessary.
- NAME OF REFERRING PHYSICIAN: to CC discharge summary to PCP is essential. Discharge summaries may not be mailed to the referring physician until several days after the patient leaves the hospital. Therefore, the discharge summary may not be suitable as an immediate notification to the physician of the patient's diagnosis and treatment. Telephone calls to referring physicians to notify them of a patient's discharge or to inquire of previous medications or events in the hospitalized patient's illness may be made.

Transfer Note:

The transfer note is essential to ensure continuity of care between ward and ICU, and when transfer of specialty occurs (e.g. medicine to surgery). The essential elements are as follows:

- ADMISSION DATE
- ADMISSION SERVICE: list attending and resident
- TRANSFER DATE
- TRANSFER SERVICE: list attending and resident
- ADMISSION DIAGNOSIS
- SECONDARY DIAGNOSIS
- CONSULTATIONS
- PROCEDURES
- HOSPITAL COURSE: summary of why patient was admitted and what has been done thus far
- PE
- LAB: transferring day's lab
- IMAGING: transferring day's imaging
- ASSESSMENT AND PLAN: by system account of what has been discovered, what needs to be f/u on and what future plans of care include

HOSPITAL DICTATION

Use for inpatient, observation, ODS, and hospital procedures.

For Clinic Visits, see instructions for Embedded Dictation.

1. To access the system: 501-526-4500 or 1-866-250-2939
   Speed Dial: Hospital and FCM: Dial Extension **#55**
   OPC-North and JTS Bldg: Press **SPUSER** > **55**
   OPC-South, Cancer Institute, and OR: Press **OUTGOING** > **Sys Speed** > **555**
2. When the dictation system answers:
   1) Enter **Physician ID** followed by the **# key.**
   2) Enter **Work Type** (2 digits; see below) followed by the **# key.**
   3) Enter patient's **Medical Record Number** (MRN) followed by the **# key. Please do NOT enter leading 0's**.
   4) Verify patient name by pressing 1 or press 2 to re-enter MRN.
   5) Dictation Job Number will play back. (System will go into Pause Mode).
   6) Press **2** to begin recording.
   7) State your full name, patient's full name and MRN, date of service, and attending physician.

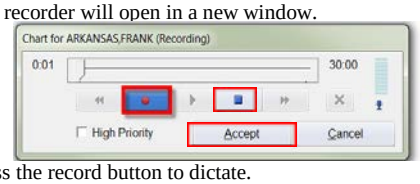
Work Types

Hospital:	**Cardiology:**
02 Operative Report	10 Cardiac Cath

03 Discharge Summary	52 Event Monitor 53 Holter Monitor

For ATTENDING PHYSICIAN use only:
01 Attending Inpatient H&P
06 Attending Inpatient Consult
15 Attending Inpatient Progress Note

- Reports will be routed to both the resident and attending to sign in Epic.
- To send copies (cc's): State the FULL name, city, and state of any physicians who need to receive a copy of the report.
- If any digits are entered incorrectly, please state corrections in the dictation.
- At any time, press 4 to review the last few words. Press 2 to resume dictation at the end of playback.

<table>
<tr><td colspan="3"></td><td>EMBEDDED DICTATION
Can be used for all note types, including clinic visits.</td></tr>
<tr><td>1</td><td>2
Record/
Resume
Recording</td><td>3</td><td rowspan="4">Log into Epic and locate your patient.
Locate or create the appropriate note.
Click on the microphone icon.
● The recorder will open in a new window.
 

● Press the record button to dictate.
● Press the stop button to end recording.
● Press Accept to complete dictation.
A link to the voice file is stored in Epic and can be played by any user.
The note voice file will be sent to a UAMS transcriptionist.
The transcribed note will appear in your Epic In Basket for signature.
The transcribed note will replace the voice file link upon signature.

NOTE: Copies (cc's) cannot be sent with embedded dictation.
Please do not dictate a request for copies (cc's) to be sent.
These notes must be sent out of Epic.</td></tr>
<tr><td>4
Short
Rewind</td><td>5
Save and
Create
Next
Report</td><td>6
Short Fast
Forward</td></tr>
<tr><td>7
Rewind to
Beginning</td><td>8
Pause</td><td>9
Fast
Forward
to End</td></tr>
<tr><td>*</td><td>0
Return to
Main Menu</td><td>#</td></tr>
</table>

Transcription may be expedited (stat) for **patient care purposes**.
To expedite transcription of a dictated note, please call: 526-2200.
Dictation services are provided by UAMS Health Information Management Department
For questions please call: 526-2200 himtranscription@uams.edu

BRIEF GUIDE TO DEATH DOCUMENTATION, REPORTING, CERTIFICATION, AND THE AUTOPSY AT UAMS

In order for you to be notified when an autopsy is performed or to be contacted with preliminary results, you must list your name and pager number on the Autopsy Status Form.

All deaths occurring in any UAMS patient care setting, either inpatient or outpatient, must be documented in the patient's medical record. In addition, a seemingly endless ream of paperwork must be completed, including the Death Report, the Arkansas State Dept. of Health Death Certificate, and when applicable, autopsy requests. In certain circumstances, the coroner or law enforcement officials may need to be notified. The medicolegal details of all of these activities are available in the UAMS Policy and Procedure Manual, Policy # L-1, legal section [www.uams.edu/UH/policy/Medical%20Legal/ml-toc.htm] The following is intended to be a simple guide for residents on the front lines. This is not intended as a legal document, but rather as guidelines for working through the administrative steps surrounding a death and autopsy.

When a death occurs, the resident should work with the nursing supervisor to complete the death reporting process. The supervisor will guide the resident through the process to ensure that all reports are completed according to UAMS policy and State law. This process must be done online through https://adherave.arkansas.gov/erave/do/login.

The Arkansas State Dept. of Health Death Certificate.

This must be completed and signed by a physician, and clipped to the front of the chart. If an autopsy is to be performed, this form must accompany the patient, along with the chart, to the morgue. You may defer the death certificate until after the provisional autopsy findings are reported (within 48 hours of autopsy), but you must note that you are doing this prior to performance of the autopsy.

Referral for Organ and Tissue Donation

You are required to notify ARORA if a death is anticipated, who then will talk with the family.

Notification of the County Coroner

A rule to live by is, "if in doubt, notify the coroner immediately." Any physician attending the patient may call the coroner or designate another to do so. Basically, you should call them if you suspect death is:

- The death appears caused by violence, homicide, suicide, or accident. Remember, if a person is in an accident, then dies in the hospital six weeks later of a PE, it is still an accidental death and must be reported!!
- You suspect there are drugs or poisons present.
- The dead person was in a mental institution, police custody, or nursing home, or within 5 days of discharge from a nursing home or jail.
- Physical abuse is suspected.
- There is no previous medical history or apparent cause of the death.
- The death is sudden or unexplained, or appears to be due to other than natural causes.
- The death occurs at a place of work.
- No physician was in attendance within the prior 36 hours, or 30 days in the case of terminal or bedfast patients.
- The person was admitted unconscious.
- The patient dies within 24 hours of admission.
- The patient was DOA or died in the emergency room.

Failure to notify the coroner is a Class A misdemeanor. Again, if in doubt, call them at 340-8355. If other officials need to be notified (sheriff, police, medical examiner), the coroner's office will take care of it.

The Autopsy Request/Autopsy Status Report (MR 39).

Autopsy requests should be made upon all deaths. That's right, ALL deaths. Autopsies serve as an unparalleled teaching tool for all of us, as well as a quality assurance mechanism for the hospital as a whole. We routinely perform postmortem examinations on inpatient deaths; UAMS patients who die outside the hospital are done on a case-by-case basis upon approval of the service director.

Full, complete autopsies or many kinds of limited dissections can be performed. Routine autopsies are performed from 8AM to 3PM, all days of the week. If need arises, though, as it sometimes does when specimens are needed for special procedures, autopsies can be done at any time in most cases. These special cases require approval of the attending pathologist on duty; don't promise anything unless you've talked to them. If any questions arise, please contact the Autopsy Service Director (Dr. James Waldron, 688-6671) or have the operator locate the pathologist on call.

Autopsies are especially strongly recommended under the following conditions:

- unanticipated deaths

- patients on experimental treatments
- intraoperative deaths
- death within 48 hours of surgery or an invasive procedure
- during pregnancy or peripartum
- psychiatric inpatients
- pediatric deaths

How to get an autopsy

The following things are necessary in order for an autopsy to begin:

- A properly identified body (toe tag, wrist band, etc.)
- A properly executed autopsy status/consent form signed by next of kin

Getting Consent

If you are unsure of how to request an autopsy from the next of kin, ask your supervising resident or attending for help. Any physician attending the patient may obtain consent. You need this physician's signature (first witness), the closest next of kin's signature, and that of another UAMS employee (second witness). The case cannot be done without this properly obtained consent. The next of kin who signs this form ideally is the person who assumes funeral responsibilities. Generally, this is the priority list for next of kin (see third page of autopsy consent form): spouse > child > parent > sibling > other first degree relative > other second degree relative > any other relative > friend assuming responsibility for burial. Common Law and other domestic partnerships don't count in Arkansas.

Filling Out Autopsy Status Form

- List clinical concerns/reason for autopsy
- List physicians who wish to be contacted with preliminary results
- List any restrictions for autopsy (this MUST be completed before the autopsy can start.)

NEEDLE STICK PROCEDURE

It is extremely important for residents to know the policy and procedures for needle stick/sharp injuries and blood/body fluid exposure in order to ensure safety and care of themselves and the students who work with them. The UAMS Medical Center policy http://intranet.uams.edu/uh/Policy/Policy-PDF/Human%20Resources/HR401.pdf which describes all procedures, in detail, which must be followed if a resident or student sustains a needle stick injury or blood/body fluid exposure. The most important points of that policy are:

Any resident who suffers a needle stick, cut, or mucus membrane (e.g. splash to the eye or mouth) exposure to blood or other body fluids, or who have a cutaneous exposure involving large amounts of blood or prolonged contact with blood regardless of the type of exposure or risk status of the source patient shall:

- Report the incident immediately to their supervisor or instructor.
- Call immediately to Employee Health/Student Preventative Health Services (EH/SPHS), 686-6565 or page 501-405-6734, if it is during regular business hours OR the Emergency Department (ED) 686-6236, if it is after business hours.
- The amount of risk incurred as a result of the exposure must be evaluated and prophylactic treatment must be started within 2 hours to be effective.
- Complete the UAMS Incident and Injury (I&I) Report form – Employee Injury Form

Information about the source patient shall be documented on the Employee Incident and Injury (I&I) report form by the nursing supervisor or his/her designee from which the source patient is receiving care. The I&I form shall accompany the resident to EH/SPHS or the ED at the time of the initial evaluation.

It is the responsibility of the resident's attending physician to make sure that all information relevant to the I&I has been completed and the resident has called either EH/SPHS or the UAMS ED, for triage. It is the responsibility of the Nursing Supervisor or designee to record all information regarding the source patient on the I&I, notify either EH/SPHS or the ED with the risk factors for HIV, and ensure that orders are written for lab work on the source patient's chart.

RESIDENCY OFFICE-DEPARTMENT OF INTERNAL MEDICINE

The Department of Medicine Residency Office controls all business functions in the Department of Internal Medicine involving House Staff affairs. The following information should help you identify certain areas in which the Medicine Residency Office can be of help to you.

- Meal Allowance: UAMS--The UAMS ID badge will be used to pay your meals when you are on ward and ICU call at the University Hospital. The ID badge is credited electronically for the upcoming month. The cost for replacement of an ID badge is $10. If you encounter any difficulty when purchasing food or if you lose your ID badge, you must notify the Residency office (686-5162). VAH--For those residents with food allergies or who may be vegetarians, the VA Nutrition and Food Service (NFS) has agreed that they will change the menu to accommodate (including the on-call boxed food), if they receive notice ***within 24 hours of the need***. Mail the request to this VA mail group: VHALIT NFS Supervisors or if outside the VA e-mail: VHALITNUTRESIDENTS@va.gov.
- Paychecks: Your pay is deposited directly to your specified institution. To view your pay stub, go to: https:\\enterprise.uams.edu\irj\portal
- Pagers: An alpha-numeric pager will be assigned to you and will remain with you throughout your training. Batteries will be supplied by the Medicine Residency Office.
- Mailboxes: Periodically, check your mailbox located in the resident lounge area. House staff members frequently miss important correspondence because they do not check their mailboxes.
- E-mails: All information important to residents will be sent electronically. You have an e-mail address at UAMS. This is on Outlook and is accessible from any internet connected computer in the world. You are responsible for any information sent to you via e-mail. "I don't check my e-mail" is not a valid excuse! Residents are expected to check UAMS e-mails on a daily basis and are expected to keep their e-mail boxes cleaned out periodically (if your mailbox is full, you cannot receive e-mail). You will also be assigned a VA e-mail address and this account should be checked periodically.
- Personal Information Changes: Please notify the Medicine Residency Office when you have changes in your address, telephone number, marital status, etc.
- Book fund: The Department of Medicine furnishes an educational book fund at each level of internship and residency. Medicine PGY-l's receive $100, PGY-2's $200, and PGY-3's $200. Medicine/Pediatric PGY-l's receive $50, PGY-2's $l00, PGY-3's $l25, and PGY-4's $l25. You may not purchase books as an individual and be reimbursed by the Department. UAMS Procurement Services can, on the resident's behalf, purchase books from Amazon and various other book vendors using a P-Card, as well as most subscriptions, dues and journals. If you would like to use this fund for any other educational purposes, such as paying for USMLE exams or ABIM board exam fees, you must have it approved before the fact by the Medicine Residency Office. You may carry book fund money over from year to year. You must use your fund by the last month of your final year of residency.