PROGRAM MANUAL

for
Residents in the Department of Medicine
University of Kansas School of Medicine
Kansas City, Kansas

This Manual compliments the GME Policy and Procedure Manual of the University of Kansas School of Medicine, Office of Graduate Medical Education:  http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

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Table of Contents

I. Introduction ................................................................................................................................................. 3

II. Academic ................................................................................................................................................ 3
   A. Mission ............................................................................................................................................... 3
   B. Performance Expectations .................................................................................................................... 4
   C. Educational Plan ................................................................................................................................. 6
   D. ABIM Requirements ............................................................................................................................ 7
   E. Internal Medicine In Training Examination ....................................................................................... 9
   F. Policy on ACGME Guidelines: ambulatory assignments and patient loads ..................................... 9
   G. Evaluation .......................................................................................................................................... 11
   H. Conferences/Curriculum ..................................................................................................................... 12
   I. Scholarly Activity ............................................................................................................................... 13
   J. Electives ............................................................................................................................................. 13
   K. Procedures ....................................................................................................................................... 14
   L. Honors and Awards ............................................................................................................................ 15
   M. Professional Responsibility and Issues of Impairment or Fatigue Mitigation .................................. 15
   N. Eligibility, Recruitment, Promotion, Deficiency and Remediation ................................................ 16
   O. Grievance Procedure ......................................................................................................................... 16

III. Hospital and State Regulations ........................................................................................................ 17
    A. Kansas Licensure .............................................................................................................................. 17
    B. BLS and ACLS ................................................................................................................................. 17
    C. Medicolegal Concerns ....................................................................................................................... 18
    D. Ethics ............................................................................................................................................... 18
    E. Order Writing .................................................................................................................................... 18

IV. Department Rules/Understanding ................................................................................................... 19
    A. Policy for Supervision of Residents and Progressive Responsibility for Patient Care ................. 19
    B. Clinical and Educational Work per Week ......................................................................................... 24
    C. Pagers .............................................................................................................................................. 25
    D. Communication with Referring Physicians .................................................................................... 25
    E. Special circumstances in regard to routine services, admission limits and covering non-teaching patients ............................................................................................................................................... 26
    F. Absences, notification, days off ........................................................................................................ 26

V. Benefits ................................................................................................................................................ 26
    A. Parking ............................................................................................................................................. 26
    B. White Coats ..................................................................................................................................... 26
    C. Access to Medical Literature and Board Preparation Materials .................................................... 26
    D. Vacation .......................................................................................................................................... 27
    E. Fitness Center ................................................................................................................................... 27
    F. ACP Membership ............................................................................................................................. 27
    G. Sick Leave ....................................................................................................................................... 28
    H. Wellness Sessions ............................................................................................................................. 28
    I. Leave of Absence: FMLA and Non-FMLA Leave of Absence ....................................................... 28
    J. Moonlighting .................................................................................................................................... 29
    K. Professional Leave ........................................................................................................................... 29
    L. Scholarship / Educational Benefits and Funds ................................................................................. 28

VI. Other .................................................................................................................................................... 30
    A. House Staff Recruitment .................................................................................................................. 30
    B. Fellowships .................................................................................................................................... 30
    C. Verification of Training .................................................................................................................... 31

Appendix A – ACGME Reporting Milestones ....................................................................................... 33
Appendix B – GMEC Resident Supervision Template .............................................................................. 37
Appendix C – ACGME Clinical and Educational Work per Week .............................................................. 43
Appendix D – Clinical Competency Committee ....................................................................................... 44
Appendix E – Program Evaluation Committee ....................................................................................... 46
I. Introduction

Welcome to the Department of Medicine at the University of Kansas Medical Center. As a member of the training program here, you are joining a rich tradition. The University of Kansas Medical School was founded on this site in 1906. From the beginning, the Department of Medicine has been at the forefront of education, research, and training for the Medical School and the location of many visible and prestigious accomplishments in the Midwest.

The accomplishment for which the Department is most proud is the character and quality of its graduates. Graduates of our training program constitute the largest group of internists in Kansas. Throughout the Midwest, the quality of our training program is recognized by hospitals and medical groups, making our graduates highly sought after for various clinical positions. Our Department takes great pride in training highly skilled internists.

The training program utilizes three training sites: The University of Kansas Hospital is the principal training site, and additional rotations occur at the Kansas City VA Hospital and the Leavenworth VA Hospital. The educational rationale for presence at each training site is carefully considered. Clinical experience at the University of Kansas Hospital is the cornerstone of our residency training program because of its opportunities for residents to learn under the mentorship of both clinical investigators and medical educators, while caring for a patient population which includes tertiary care referrals from physicians throughout the region, as well as the local, culturally diverse primary care population. Our educational affiliation with the Kansas City VA Hospital is designed specifically to expose residents to a practice setting with increased autonomy, yet adequate faculty supervision, and a patient population with a different spectrum of disease than our university hospital. Residents also spend 3-6 weeks in their three years of training at the Leavenworth VA Hospital training site, designed to expose them to a rural, generalist-dominant setting which is representative of health care provision in many parts of our state. Creating a work environment at each of these training sites that is conducive to the maintenance of health and well-being of our resident physicians is of utmost importance. Please see the GME manual section 5.8.3 for a detailed outline of our work environment expectations:

http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

II. Academic

A. Mission

The KU Department of Internal Medicine strives to achieve excellence in its three-fold mission of patient care, teaching, and research. Our Department is committed to providing outstanding clinical service to its patients and the community, exceptional medical education for medical students, residents, and other health professionals, and innovative research to expand the frontiers of biomedical knowledge and clinical practice.

The Internal Medicine Residency Program seeks to educate residents to be outstanding practitioners, lifelong learners, critical thinkers, and patient advocates. The Program seeks to provide an educational environment conducive to a lifetime of study, problem solving, and excellent clinical judgment in the practice of internal medicine. To this aim the Program seeks to: 1) Promote maximum achievement in each resident by identifying their individual strengths and weaknesses in the core competencies of internal medicine; 2) Develop measures designed to improve deficiencies, and assess progression toward mastery in each of the six defined core competencies which include: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal Skills and Communication, Professionalism, and Systems-Based Practice; 3) Foster a commitment to academic achievement by emphasizing the importance of research and investigation both as a career choice and as a means of incorporating principals of critical thinking into each resident’s clinical practice, continuing education, and professional development; 4) Work with each resident to formulate long-term career goals in the disciplines of internal medicine including primary care, hospital based practice, subspecialty medicine, academic/research or practice-based medicine; 5) Ensure that each resident is successful in becoming a board eligible and board certified physician in internal medicine.
B. Performance Expectations

The Department of Internal Medicine utilizes milestone based performance criteria for the advancement/promotion of its residents. The Department has adapted the Internal Medicine curricular milestones to create overall educational goals and objectives for residents at each level of training. These milestones serve as the basis for performance expectations, as well as evaluation of residents, and serve as a tool for development of reports submitted to the ACGME twice yearly documenting each resident’s performance. (see Appendix A).

The final decision of whether to promote or graduate a resident is determined by the Residency Program Director, taking into consideration input received from the Clinical Competency Committee as well as the faculty of the Department. (See Appendix D for written policy related to expectations / assignment of the Clinical Competency Committee.) Utilizing an electronic evaluation format, each resident is evaluated on each rotation in the six aforementioned competencies by his/her attending physician. Additionally, the program seeks feedback in a 360 degree evaluation structure, including from self, peer residents, medical students, clinic preceptors, nursing personnel and patients. The goal is to achieve a multi-source evaluation of the resident’s work and communication skills.

<table>
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<tr>
<th>Multi-Source Evaluation Process</th>
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<tbody>
<tr>
<td>Self</td>
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<tr>
<td>Faculty</td>
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<tr>
<td>Medical Students</td>
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<tr>
<td>Resident Peers</td>
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<tr>
<td>Patients</td>
</tr>
<tr>
<td>Nursing/Ancillary Medical Personnel</td>
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Within a rotational experience, the program expects that the attending and resident speak directly about his/her evaluation at minimum at the completion of each rotation. Residents have electronic access to their evaluations as well. Evaluations play a key role in deciding whether or not to advance a resident to the next level of training. Each resident is assigned two faculty advisors: a program director and a core faculty. The resident’s program director advisor as well as the resident’s assigned core faculty advisor regularly reviews evaluations in a structured manner. Residents receive direct feedback on a semiannual basis by way of a documented meeting with their program director advisor to discuss content of these evaluations amongst other performance measures, including a review of the ACGME milestones evaluation report.

The criteria for advancement and final matriculation from the residency program are based upon the satisfactory achievement of the following core competencies as outlined by the American College of Graduate Medical Education (ACGME). The competencies are listed below:

**Patient Care**
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of problems and the promotion of health. Residents:

1. Are expected to demonstrate the ability to manage patients:
   a. In a variety of roles within a health system with progressive responsibility to include serving as the direct provider, the leader or member of a multidisciplinary team of providers, a consultant to other physicians, and a teacher to the patient and other physicians
   b. In the prevention, counseling, detection, and diagnosis and treatment of gender-specific diseases
   c. In a variety of health care settings to include the inpatient ward, the critical care units, the emergency setting and the ambulatory setting
   d. Across the spectrum of clinical disorders seen in the practice of general internal medicine including the subspecialties of internal medicine and non-internal medicine specialties in both inpatient and ambulatory settings
   e. Using clinical skills of interviewing and physical examination
f. Using the laboratory and imaging techniques appropriately  
g. By demonstrating competence in the performance of procedures mandated by the ABIM  
h. By caring for a sufficient number of undifferentiated acutely and severely ill patients

2. Must treat their patient’s conditions with practices that are safe, scientifically based, effective, efficient, timely, and cost effective. The program must integrate patient-centered care and resident education. On all assignments, residents and faculty interactions must be patient-centered.

Medical Knowledge
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care. Residents:

1. Are expected to demonstrate a level of expertise in the knowledge of those areas appropriate for an internal medicine specialist, specifically:
   a. Knowledge of the broad spectrum of clinical disorders seen in the practice of general internal medicine  
   b. Knowledge of the core content of general internal medicine which includes the internal medicine subspecialties and non-internal medicine specialties  
   c. Relevant non-clinical topics at a level sufficient to practice internal medicine

2. Are expected to demonstrate sufficient knowledge to:
   a. Evaluate patients with an undiagnosed and undifferentiated presentation  
   b. Treat medical conditions commonly managed by internists  
   c. Provide basic preventive care  
   d. Interpret basic clinical tests and images  
   e. Recognize and provide initial management of emergency medical problems  
   f. Use common pharmacotherapy  
   g. Appropriately use and perform diagnostic and therapeutic procedures

Practice-Based Learning and Improvement
Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

1. Identify strengths, deficiencies, and limits in one’s knowledge and expertise  
2. Set learning and improvement goals  
3. Identify and perform appropriate learning activities  
4. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement  
5. Incorporate formative evaluation feedback into daily practice  
6. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems  
7. Use information technology to optimize learning  
8. Participate in the education of patients, families, students, residents and other health professionals

Interpersonal and Communication Skills
Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds  
2. Communicate effectively with physicians, other health professionals, and health related agencies  
3. Work effectively as a member or leader of a health care team or other professional group  
4. Act in a consultative role to other physicians and health professionals  
5. Maintain comprehensive, timely, and legible medical records
Professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

1. Compassion, integrity, and respect for others
2. Responsiveness to patient needs that supersedes self-interest
3. Respect for patient privacy and autonomy
4. Accountability to patients, society, and the profession
5. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation

Systems-Based Practice:
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected:

1. Work effectively in various health care delivery settings and systems relevant to their clinical specialty
2. Coordinate patient care within the health care system relevant to their clinical specialty
3. Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population based care as appropriate
4. Advocate for quality patient care and optimal patient care systems
5. Work in inter-professional teams to enhance patient safety and improve patient care quality
6. Participate in identifying system errors and implementing potential systems solutions
7. Work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients including the transition of care between settings
8. Recognize and function effectively in high-quality care systems

In addition to all of these parameters, Internal Medicine residents are judged by whether they are competent to supervise others, to act with limited independence, and to be expected to pass the Internal Medicine Board examinations. A yearly in-service examination, the Internal Medicine In Training Examination (IM-ITE), is given to all categorical residents to assess the continued growth of their knowledge base. The Program utilizes the examination to both simulate the ABIM exam and to help the residents identify specific areas needing more attention. In addition, performance on the IM-ITE is incorporated into the programmatic evaluation of the competency of medical knowledge. Residents are expected to prepare for this examination and to give it their best effort.

Before graduation a resident must have achieved all of these competencies, be deemed competent to act independently as a professional internist, and function well interdependently with all of the other members who comprise the health care team. He/she should exhibit leadership, refined management skills, cooperation with professionals, and an appreciation for the community in which he/she practices medicine.

C. Educational Plan
The Department has established a written curriculum (rotational goals and objectives) for all aspects of its residency education and training which is distributed electronically to residents and faculty on a monthly basis via MedHub; and is available to the residents and faculty for review on our website. In addition to the mission and performance expectations noted above, the curriculum contains teaching methodology, educational materials unique to particular subspecialty divisions, types of clinical encounters, patient population and sites of training, diagnostic and therapeutic procedures specific to or generally employed by a particular division, and a listing of the scheduled divisional conferences that a resident should avail themselves to while on that particular service. Most importantly, the curriculum contains a list of objectives for each level of training. These learning objectives are meant to be the minimum achieved while on each service.

As noted, all residents are expected to become familiar with the American Board of Internal Medicine (ABIM) requirements for the various subspecialties in Internal Medicine, as well as those areas required by the Residency Review Committee (RRC). Nonetheless, the curriculum in Internal Medicine is not intended to be identical for every Housestaff. Individual residents will be given every opportunity to
choose electives and opportunities to become proficient in procedures and skills that may be important or required for their particular career pathway.

The curriculum is balanced between inpatient and outpatient requirements, acute and chronic care, and problems of the young adult, middle-age, and elderly (geriatrics). The percentage or emphasis is largely determined by ABIM and RRC requirements and recommendations. For a categorical medicine resident, at least one-third of their time is spent on ambulatory medicine, made up of 130 clinic sessions in conjunction with general and specialty medicine inpatient and outpatient rotations, and the required geriatrics, neurology, and ER rotations. All services have a required academic or teaching rounds component in addition to patient service rounds.

In addition to the clinical curriculum, the Department has five weekly one hour Core Conferences, which residents are required to attend. These are broadcast to the Veterans hospitals in Kansas City and Leavenworth. These presentations are delivered by faculty physicians, as well as the Internal Medicine Chief Residents, and are recorded and available for residents to review on the internal medicine residency website. The core conference series is designed to prepare residents for their certification examinations, and to meet the Residency Review Committee in Internal Medicine’s requirements for education in both Internal Medicine and non-Internal Medicine specialties. In addition to the core conferences, there are required online ambulatory modules (PEAC), Grand Rounds once a week, and monthly Friday School. Ethics sessions and Journal Club are held monthly. Clinical Pathology Conference is held quarterly with Patient Safety Conference held every other month. Attendance is required at ≥50% of these mandatory Internal Medicine conferences unless rotational assignment does not allow physical attendance; when this is the case, lectures may be reviewed via podcast.

Each division also has their own regularly scheduled set of conferences, which are to be attended by the resident(s) rotating on that service assuming they do not conflict with the above required educational experiences. These conferences generally cover the areas of Basic Science, Clinical Discussion, Journal Club, and Research Update in a subspecialty content area. It is the responsibility of each Internal Medicine subspecialty to orient and train residents on their service in those interpretive skills and procedures that are unique to their division.

The residents are also required to participate in a variety of simulation activities throughout the year. First year residents participate in simulations with cases involving end of life, code status conversations, and management of the hypotensive patient. All PGY levels participate in multidisciplinary Code Blue simulations and Central Venous Catheter (CVC) insertion sessions. During the CVC sessions, principles regarding all procedures (sterile technique, consent, time out, basics of ultrasound, etc.) are discussed. There are multiple other simulation workshops held during Friday School sessions (tachyarrhythmia, bradycardia, ventilator, airway), as well as training in Ultrasound.

D. ABIM Requirements

Academic activities in the program are focused on assuring the eligibility of residents to sit for the certifying examination of the American Board of Internal Medicine. The ABIM outlines both in general and in specific terms the steps necessary for a resident to become eligible for taking the examination.

ABIM Board Certification demonstrates that physicians have met rigorous standards through intensive study, self-assessment and evaluation. Additionally, certification encompasses the six general competencies established by the Accreditation Council for Graduate Medical Education (ACGME) and sets the stage for continual professional development through values centered on lifelong learning. In order to be certified, a physician must:

- Complete the requisite predoctoral medical education
- Meet the training requirements
- Meet the licensure requirements and procedural requirements
- Pass a certification examination

The ABIM requires substantiation that candidates for certification are competent in clinical judgment, medical knowledge, clinical skills (medical interviewing, physical exam, and procedural skills), humanistic qualities, professionalism, and provision of medical care.

Residents are expected to show competency in understanding indications, contraindications, and
complications associated with the following procedures, as well as interpretation of results:

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<tr>
<th>Procedure</th>
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<tbody>
<tr>
<td>Abdominal paracentesis</td>
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<tr>
<td>Arterial line placement</td>
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<tr>
<td>Arthrocentesis</td>
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<tr>
<td>Central venous catheter placement</td>
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<tr>
<td>Incision and drainage of an abscess</td>
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<tr>
<td>Lumbar puncture</td>
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<tr>
<td>Nasogastric intubation</td>
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<tr>
<td>Pulmonary arterial catheter placement</td>
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<tr>
<td>Thoracentesis</td>
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Residents are expected to demonstrate competency in performance of the following procedures, generally at least 5 should be performed, in addition to understanding their indications and complications:

<table>
<thead>
<tr>
<th>Procedure</th>
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<tbody>
<tr>
<td>Advanced cardiac life support</td>
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<tr>
<td>Venous blood draw</td>
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<tr>
<td>Arterial blood draw</td>
</tr>
<tr>
<td>Pap smear and endocervical culture</td>
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<tr>
<td>Peripheral IV placement</td>
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All residents must regularly document the type and number of each procedure that has been accomplished. This documentation is done electronically via MedHub. These are maintained on a master list in each resident’s portfolio and are used at the end of the resident’s training to verify competence in procedural medicine as set forth by the ABIM.

Board certification does not rest solely on passing the written examination. It also requires ongoing evaluation by an accredited residency program of the candidate’s performance as a physician. This is done through a resident tracking form, which is also a part of the resident’s permanent file. The ABIM requires that the Program Director attest each year that each resident is progressing satisfactorily towards competence in the practice of Internal Medicine and in attaining the knowledge base to pass the Board exam. This two-fold goal is the reason behind the comprehensive evaluation process used by the Department as well as our support of objective measures of knowledge (such as requiring all categorical residents to sit yearly for the in-service examination). The Department insists on satisfactory performance in the aggregate by each resident over the course of each program year. The ABIM will not admit a candidate to the Board exam that has not been certified by the Program Director for each year of training.

The ABIM requires that the 36 month period of full-time medical residency education must include: 30 months of rotations in general internal medicine, subspecialty internal medicine, critical care medicine, geriatric medicine, and emergency medicine which may include a maximum of four months of non-internal medicine primary skill areas (e.g. neurology, dermatology, office gynecology, or pediatrics). Residents may take up to three rotations of electives with the approval of the Program Director.

The ABIM permits up to one month per academic year 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. ABIM recognizes that leave policies vary from institution to institution and expects the program director to apply his/her local requirements within these guidelines to ensure trainees have completed the requisite period of training. The ABIM also requires that the residency must contain 24 months of direct patient responsibility, which may occur in either inpatient or ambulatory settings. A minimum of six months of this direct patient responsibility on internal medicine rotations must occur during the R-1 year.
E. Internal Medicine In Training Examination

As a means of self-assessment and practice, the Department requires the Internal Medicine In Training Examination be taken by all categorical residents each year. Results from this test are confidentially shared with the Chairman, Program Director and Clinical Competency Committee. The exam is designed to show areas of strength and deficiency; and to better prepare the resident physician in studying for future exams. A report detailing performance in each area of internal medicine is given to the resident and reviewed by the resident’s program advisor. Though the IM-ITE is meant primarily as an educational tool, it does provide important objective information about a resident’s medical knowledge base, and thus is taken into consideration in the resident’s overall evaluation in the area of medical knowledge.

In addition to utilization of IM-ITE performance as an evaluation tool to assess medical knowledge, the Department uses IM-ITE performance to aide residents in ABIM readiness. Residents scoring ≤30 percentile rank when compared to peers at the same level of training will be asked to enter into a formal mentored board preparation program. This board preparation program includes the following:

- Formal learning style assessment
- Required meeting(s) with GME based educational support services
- Timely preparation and completion of Step 3 or Comlex 3
- Written board preparation plan—updated semi-annually at time of the semi-annual review
- Evidence-based directed reading program targeting ITE missed educational objectives and ABIM board preparation questions to be submitted electronically to program advisor at minimum on a monthly basis
- Scheduling consideration for subspecialty areas of identified weakness based on ITE performance and elective requests
- Consideration for participation in formal board review course

Once enrolled into the program’s board preparation program, also referred to as an educational prescription, residents will remain in this monitored program until they score >70 percentile rank on the IM-TIE.

F. Policy on ACGME Guidelines: ambulatory assignments and patient loads

All trainees are required to follow the ACGME program requirements for Residency education. The following is a listing of the guidelines as set forth by the ACGME and has been adopted for the Department of Internal Medicine residency training program. Please go to the following link for additional details:  [http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/140_internal_medicine_2017-07-01.pdf?ver=2017-06-30-083345-723](http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/140_internal_medicine_2017-07-01.pdf?ver=2017-06-30-083345-723)

1. Ambulatory Medicine – at least one-third of the residency training is in an ambulatory care setting.

   a. Longitudinal Continuity Experience
      1. Must include the resident serving as the primary physician for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients.
      2. Should not be interrupted by more than a 4 weeks, not inclusive of vacation.
      3. Must include a minimum of 130 distinct half-day outpatient sessions, extending at least over a 30-month period, devoted to longitudinal care of the resident’s panel of patients.
      4. Must include evaluation of performance data for each resident’s continuity panel of patients relating to both chronic disease management and preventive health care. Residents must receive faculty guidance for developing a data-based action plan and evaluate this plan at least twice a year.
      5. Must include resident participation in coordination of care across health care settings. Residents should be accessible to participate in the management of their continuity panel of patients between outpatient visits. There must be systems of care to provide coverage of urgent problems when a resident is not readily available.
6. Must include supervision by faculty who develop a longitudinal relationship with residents throughout the duration of their continuity experience.
7. Must maintain a ratio of residents or other learners to faculty preceptors not to exceed 4:1.
8. Must have sufficient supervision and teaching:
   a. Faculty must not have other patient care duties while supervising more than two residents or other learners
   b. Other faculty responsibilities must not detract from the supervision and teaching of residents.
9. During the continuity experience, arrangements are made to minimize interruptions of the experience by residents' duties on inpatient and consultation services.

2. Emergency Medicine
   1. Internal medicine residents must be assigned to emergency medicine for at least four weeks of direct experience in blocks of not less than two weeks.
   2. Internal medicine residents assigned to emergency medicine must have first-contact responsibility for a sufficient number of unselected patients to meet the educational needs of internal medicine residents. Triage by other physicians prior to this contact is unacceptable.
   3. Total required emergency medicine experience must not exceed 8 weeks in three years of training.

3. Inpatient Medicine
   a. On Inpatient Rotations:
      1. A first-year resident is not assigned more than 5 new patients per admitting day; an additional 2 patients may be assigned if they are in-house transfers from the medical services.
      2. A first-year resident is not assigned more than 8 new patients in a 48-hour period.
      3. A first-year resident is not responsible for the ongoing care of more than 9 patients.
      4. When supervising more than one first-year resident, the supervising resident is not responsible for the supervision or admission of more than 10 new patients and 4 transfer patients per admitting day or more than 16 new patients in a 48-hour period. (This does not apply to Night Float residents.)
      5. When supervising one first-year resident, the supervising resident is not responsible for the ongoing care of more than 12 patients.
      6. When supervising more than one first-year resident, the supervising resident is not responsible for the ongoing care of more than 16 patients, and up to 20 patients in unusual exceptional circumstances—which would be closely monitored by the program.
      7. Residents must write all orders for patients under their care, with appropriate supervision by the attending physician. In those unusual circumstances when an attending physician or subspecialty resident writes an order on a resident’s patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner.
      8. Second- or third-year internal medicine residents or other appropriate supervisory physicians (e.g., subspecialty fellows or attending physicians) with documented experience appropriate to the acuity, complexity, and severity of patient illness are available at all times on-site to supervise first-year residents.
      9. Residents from other specialties do not supervise internal medicine residents on any internal medicine inpatient rotation.
   10. There is a resident on-call system and a detailed checkout procedure, so residents learn to work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients.
   11. The on-call system includes a plan for backup to ensure that patient care is not jeopardized during or following assigned periods of duty.
   12. There is a minimum of 6 months of inpatient internal medicine teaching service assignments in the first year.
13. There is a minimum of 6 months of inpatient internal medicine teaching service assignments over the second and third years of training combined.
14. The required 12 months of inpatient internal medicine include a minimum of 3 months of inpatient general internal medicine teaching service assignments over the 3 years of training.
15. Geographic concentration of inpatients assigned to a given resident is desirable because such concentration promotes effective teaching and fosters interaction with other healthcare personnel.
16. Residents are not assigned more than 8 weeks of night float during any year of training, or more than 16 weeks of night float over 3 years of residency.

b. Inpatient Medicine -- Critical Care
   1. Residents are assigned to critical care rotations (e.g., medical intensive care units, cardiac care units) no fewer than 12 weeks in 3 years of training.
   2. Total required critical care experience cannot exceed 24 weeks in 3 years of training.
      (NOTE: When elective experience occurs in the critical care unit, it must not result in more than a total of 32 weeks of critical care in 3 years of training for any resident.)
   3. All critical care training occurs in critical care units that are directed by ABMS-certified critical care specialists.
   4. All coronary intensive care unit training occurs in critical care units that are directed by ABIM-certified cardiologists.
   5. Timely and appropriate consultations are available from other internal medicine subspecialists and specialists from other disciplines.

4. Subspecialty Experience
   a. Clinical experience in each of the subspecialties of internal medicine is included in the training program and may occur in either inpatient or ambulatory setting.
   b. Although it is not necessary that each resident be assigned to a dedicated rotation in every subspecialty, the curriculum is designed to ensure that each resident has sufficient clinical exposure to the diagnostic and therapeutic methods of each of the recognized internal medicine subspecialties.
   c. Residents have formal instruction and assigned clinical experience in geriatric medicine. The curriculum and clinical experience is directed by an ABIM certified geriatrician. These experiences may occur at one or more specifically designated geriatric inpatient units, geriatric consultation services, long-term care facilities, geriatric ambulatory clinics, and/or in home-care settings.

G. Evaluation

There are a number of ways in which residents are evaluated. The most frequent and dependable is the written and verbal evaluation by the attending physician at the end of each rotation. Faculty evaluations are based on both overall resident performance and documentation of specific episodes of direct observation of the resident in daily patient care through entrustable professional activities (EPAs) or mini-clinical evaluation exercises (mini-CEX).

Each evaluation must be discussed with the resident---if this does not occur, the resident should ask to meet with the attending for his/her evaluation. All rotational written assessments are screened by the Program Director and the resident’s program advisor. Lack of satisfactory progression towards independent practice as measured by milestones-based evaluation is cause for concern and results in counseling with the resident and close monitoring by the Clinical Competency Committee. A documented unsatisfactory evaluation, particularly following sequential or recent low satisfactory marks, makes the resident subject to probationary status, at the discretion of the Clinical Competency Committee and the Program Director (see Deficiency and Remediation section).
Semi-annually, each resident’s advisor (Program Director or Associate Program Director), meets with the resident individually. The purpose of these sessions is to review the resident’s portfolio for completion, provide feedback, counseling, assistance, and listen to suggestions. These meetings are informal and supportive --- they should not engender apprehension. Residents who have, however, had low satisfactory or worse evaluations can be expected to discuss these evaluations and put forth a plan for improvement.

In addition to regularly reviewing residents’ performance, the Clinical Competency Committee semi-annually reviews each resident’s personal file of documentation of direct observation by faculty, rotational evaluations, ITE scores, and other performance measures. A composite milestones-based evaluation is created and submitted to the ACGME for each resident. On an annual basis, reports on resident performance are submitted to the American Board of Internal Medicine as well. The Committee also determines if each resident is meeting or has met the Departmental requirements and expectations for promotion or graduation, and if not, appropriate remediation is implemented (see section on Deficiency and Remediation).

An important aspect of the evaluation process is the feedback that the Program Director receives from residents regarding the educational performance of their attending physicians. This feedback is utilized by the Program Director and Chair of Medicine to make faculty education assignments. If faculties are not able to provide adequate educational services to the residents, they will no longer be able to participate in this education process. The resident’s evaluation of faculty is anonymous; these evaluations are batched and de-identified when shared with faculty.

On an annual basis, a yearly program evaluation process is undertaken by the Program Evaluation Committee. This documented evaluation includes review of ACGME survey data, resident performance, faculty development, graduate performance, and program quality. Based on this evaluation, program goals and objectives are developed with input from program leadership, faculty, and residents.

The program takes the sensitivity of the evaluation process very seriously. When a resident evaluates a faculty member, his/her name is not linked to the evaluation. Furthermore, evaluations are released to the faculty in a batched fashion so that there is not a time stamp associated with the release of the resident evaluation to faculty. Resident peer evaluations are also anonymous; they are reviewed in a batched fashion with the resident at the time of their semi-annual review. The GME office can answer any questions about anonymity of evaluations; we want you to feel confident in the security and sensitivity of our evaluation process.

H. Conferences/Curriculum

Our Core Curriculum Conference Series is held from 12:00-1:00 pm on Monday through Friday. When applicable, these conferences are broadcasted to the KCVA and Leavenworth VA, or, in some cases, simultaneously held at affiliate sites. Each division in Internal Medicine is assigned lecture topics based on the ABIM certifying examination blue print. The conferences are podcast thus are available to those unable to attend or who want to revisit the lecture material later. Lectures included in our Core Curriculum Conference Series as follows:

a. Resident Report (either intern or senior)
b. Faculty Lectures based on ABIM certifying examination blue print
c. ACP Board Prep
d. Journal Club
e. Clinicopathologic Conference
f. Patient Safety Conference
g. Ethics Conference
h. Chief Conference
i. Debriefing Conference
Resident Report (RR) is part of the Core Curriculum Conference Series. Resident Report is one of the most important teaching activities of the Department. It is an opportunity to frame evidence based learning around interesting case examples from the inpatient or outpatient setting. The atmosphere at RR is intended to be informative and non-confrontational, however, the aim is to challenge the resident selected to discuss the case by openly analyzing his/her ability to process clinical information appropriately.

Grand Rounds is held at 8 am on Wednesday mornings. Presented by faculty or visiting professors, this is the showcase Departmental conference of the week. Every effort should be made to attend.

Departmental Housestaff meetings are held once a month. The Chief Residents prepare the agenda and the Program Director team are present to discuss items or answer questions. This is intended to be an open forum in which residents can express any concerns they have about the residency program and suggest ways to improve it.

Each division supports its own set of conferences or seminars. While on that service, resident attendance is expected at these programs, however priority is given to the program run conferences. Multiple special interest conferences are held daily on campus. These are listed on the weekly calendar at the KU website and details about the event are posted throughout the hospital.

Attendance at core conference is expected. Residents are expected to willingly take part in these conference opportunities. However, in order to ensure that minimum attendance requirements are met, attendance is taken at each conference. Attendance is tracked via an electronic tracking system; each resident is responsible for logging his/her attendance by way of this electronic tracking system. Attendance is required at ≥50% of these mandatory Internal Medicine conferences unless rotational assignment does not allow physical attendance; when this is the case, lectures may be reviewed via podcast. It is important that residents make up the educational component missed by not attending conference; this can be achieved via podcast for most core conferences. Conference attendance credit will be granted for viewing recorded core conferences by e-mailing Ashley Sims (asims3@kumc.edu) if submitted by advertised deadline. Residents will be notified of their attendance percentage on a regular basis, to allow adequate time for improvement before corrective measures are required.

I. Scholarly Activity

Categorical residents are required to conduct two scholarly activities during their residency. This requirement is met by dissemination of scholarship at a local, regional or national conference or by way of a peer-reviewed publication.

Each resident is expected to make several presentations during his/her residency. These may take the form of conducting a journal club, presenting at CPC or PSC conferences, presenting at Resident Report, or various other short presentations as directed by the attending physician. While such presentations are an invaluable component of residency training and meet ACGME requirements for scholarship, they do not qualify as the type of dissemination of scholarship as required by the program.

J. Electives

The Department enthusiastically supports residents who wish to engage in research projects and supplemental clinical experiences during their training to explore opportunities outside of the traditional residency program.

All efforts will be made to accommodate research and clinical experiences and residents can have up to three elective experiences during their training provided the following criteria are met: 1.) The resident is deemed in good standing by the Program Director. 2.) The resident is compliant with programmatic expectations of Medical Knowledge assessment and development as reflected by IM-ITE results (>30%ile rank) and evaluation data. 3.) The resident identifies a research/clinical mentor who will work closely with the resident and Program Director. 4.) The resident submits the required elective application paperwork in the appropriate timeline to the program leadership. 5.) The clinical workload of the residency program allows for the elective time. This information is detailed on the program website at the following link: http://www.kumc.edu/school-of-medicine/internal-medicine/residency-program/program-
Research electives, internal medicine based electives and electives outside of the Department of Internal Medicine (such as radiology, orthopedics, trauma surgery, gynecology, community ambulatory, etc.) can be arranged. As above, starting or continuing on an elective rotation is contingent upon meeting programmatic requirements available at http://www.kumc.edu/school-of-medicine/internal-medicine/residency-program/program-initiatives/elective-rotations.html. If a resident fails to meet these requirements, he or she will be assigned to another rotation.

For each elective request, a resident must submit an Elective Rotation Application. For on-site electives, applications must be submitted at least three months prior to their elective start date. For off-site electives, applications must be submitted six months prior to the elective start date and the Graduate Medical Education departmental checklist for away rotations must be completed. For all experiences, a faculty mentor needs to be identified, and the faculty member must email IMCHIEFS@kumc.edu and responsible Associate Program Director for Elective Rotations to acknowledge acceptance of that role. Each resident will act independently in creating a successful elective experience, thus it is crucial to have a plan in place to have a productive and educational rotation. It is our goal to provide direction and leadership to help our residents be successful.

Residents selected for chief resident positions are required to complete an Administrative Medicine elective rotation prior to the start of their chief residency year. During this rotation, incoming chief residents work closely with program leaders to develop goals for the upcoming year, gain an understanding of leadership and administrative principles, create the rotational schedule using data gathered from the schedule build session and intern request forms, partner with the administrative on orientation preparation as well as complete all licensure and credentialing responsibilities for each clinical practice site.

K. Procedures

As discussed above, our procedure curriculum is achieved via a variety of avenues. Our program provides a formal procedural curriculum via utilization of the Simulation Lab. Residents also have the opportunity to take part in bedside procedures at all clinical sites.

Residents are expected to consent patients prior to the procedure that they are performing. Informed consent is obtained after explaining to the patient and family the indications for the procedure, expected benefits of the procedure, alternatives to the procedure and potential complications of the procedure. Residents are not expected to consent patients for procedures that they are not personally performing or assisting.

Departmental procedural supervision requirements can be found in appendix B. This information is available in an electronic database (MedHub) so that all clinical staff members have information immediately available to determine procedural level of supervision required.

A resident must always get approval to do the procedure from attending of record. The attending of record must be credentialed to do the procedure for the resident to participate in any aspect of the procedure and with all degrees of supervision.

Procedural Certification Process (see appendix B for details on procedural EPA):

In order for a resident to perform a procedure without direct supervision, he/she must have completed the following documented in MedHub:

- Arterial line
  - 3 successful, directly observed procedures
  - Expressed confidence in completing the procedure on his/her own via self-evaluation
  - At least one procedural EPA documented from a board certified physician with a level 4 or 5 achieved.

- Knee arthrocentesis
  - 3 successful, directly observed procedures
  - Expressed confidence in completing the procedure on his/her own via self-evaluation
- Central line
  o 5 successful, directly observed procedures
  o Expressed confidence in completing the procedure on his/her own via self-evaluation
  o At least one procedural EPA documented from a board certified physician with a level 4 or 5 achieved.
- Lumbar puncture
  o 5 successful, directly observed procedures
  o Expressed confidence in completing the procedure on his/her own via self-evaluation
  o At least one procedural EPA documented from a board certified physician with a level 4 or 5 achieved.
- Paracentesis
  o 5 successful, directly observed procedures
  o Expressed confidence in completing the procedure on his/her own via self-evaluation
  o At least one procedural EPA documented from a board certified physician with a level 4 or 5 achieved.
- Thoracentesis
  o 5 successful, directly observed procedures
  o Expressed confidence in completing the procedure on his/her own via self-evaluation
  o At least one procedural EPA documented from a board certified physician with a level 4 or 5 achieved.

L. Honors and Awards
The Department is proud of its residents. Outstanding residents are recognized with several honors and awards. Benefactors in the community also understand the importance of recognizing outstanding performance and have endowed some of the awards. The individuals who receive these awards are elected by a vote of the faculty.

Each year in June, the Department holds its awards breakfast where the graduating R3s are especially recognized and awarded. The Intern of the Year award goes to a deserving R-1 for outstanding performance. Each resident (R2 and R3) selected as House Staff of the year is presented the Milton McGreevy award. These three awards consist of a plaque and an honorarium. (Once selected as House Staff of the year, you are not again eligible.)

A special honor is the Marc Beck Award. Given in memory of Dr. Marc Beck, who was tragically killed during his residency, the award is presented to the resident who displays the highest standards of caring and compassion. This plaque rewards the humanistic aspect of doctoring and is one of the most meaningful gestures the Department can convey.

Additionally, the Pingleton Award is given to a resident felt to demonstrate exemplary service to the residency and the medical community.

Medical students who rotate through the Department at the MS3 level vote for the Outstanding Resident Teacher Award. Medical students also recognize resident teaching through the Student Voice Awards.

M. Professional Responsibility and Issues of Impairment or Fatigue Mitigation
Residents are expected to appear for duty appropriately rested and fit to provide the services required by their patients. Satisfactory performance includes the absence of significant impairment (impaired function of a resident to a degree that it is causing less than satisfactory performance, and/or the impaired function, if not corrected or is uncorrectable, is likely to lead to future unsatisfactory performance) due to physical, mental, or emotional illness, excessive fatigue, or substance abuse. Every effort will be made to reasonably accommodate those individuals with conditions or impairments that qualify as a disability under applicable law, provided that the accommodation does not present an undue hardship for the Department, the Medical School, or venues of training. Residents will nevertheless be required to satisfactorily meet the Department’s performance criteria, requirements, and expectations of the Medicine
Residency Program. Please refer to Kansas University Medical Center’s Graduate Medical Education Policy Manual for the details of institutional policy regarding fatigue mitigation and impairment.

Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

- assurance of the safety and welfare of patients entrusted to their care
- provision of patient-and family-centered care
- assurance of their fitness for duty
- management of their time before, during, and after clinical assignments
- recognition of impairment, including illness and fatigue, in themselves and in their peers
- attention to lifelong learning
- the monitoring of their patient care performance improvement
- honest and accurate reporting of duty hours, patient outcomes, and clinical experience data

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

In addition to the above expectations, the program expects that each resident will properly introduce themselves to each patient, including an explanation of their role as part of the caregiver team.

N. Eligibility, Recruitment, Promotion, Deficiency and Remediation

The program complies with the policies set forth in the University of Kansas Graduate Medical Education Manual for eligibility, transfer, application, selection and appointment of residents. Please see GME Manual Section 4 for details in this regard.

Should a resident be found to be deficient in any of the criteria or parameters of performance and not meet advancement or promotion specifics, he/she will meet with the Program Director, the Associate Program Director, or their designee wherein 1) The expectations and deficiencies will be stated, 2) What the individual can do to improve will be explored and planned, and 3) An attempt will be made to determine if there are outside factors which may explain why a problem has developed. At this point a determination may be made by the Clinical Competency Committee of whether a specific performance improvement plan or a more formal period of Performance Warning Status (PWS) is indicated. The PWS will involve a period of three months, where the performance of the resident can be monitored more closely. PWS is designed to identify weaknesses that, if not remedied, may lead to probation or dismissal. The Program Director, Associate Program Director, or their designee will be responsible for determining the process for remediation. This meeting will be documented, given to the resident for his/her agreement of the meeting content, and a final copy will go into the resident’s personal file. Unless otherwise stated, a resident in Performance Warning Status is still considered to be in good standing and does not have to report this action on future professional applications. Should, however, the resident be placed in Performance Warning Status again after the initial 3 month period, he/she is eligible to be placed on probation, as described in the GME Policies and Procedures Manual. In some circumstances involving serious performance concerns, the Clinical Competency Committee may elect to place a resident directly onto probationary status without a period of Performance Warning Status.

Resident contracts are renewed on a yearly basis, subject to the discretion of the program leadership. Similarly, if a resident is thinking about leaving his/her position in Internal Medicine it is advised that he/she meet with the Program Director as soon as possible to discuss this matter.

O. Grievance Procedure

Grievable matters are those relating to the interpretation of, application of, or compliance with the provisions of the Resident Agreement, the policies and procedures governing graduate medical education,
Complaints of illegal discrimination, including failure to provide reasonable accommodations and sexual harassment, are processed in accordance with the Medical Center policies and procedures that are administered through the Equal Opportunity Office.

Should a resident in the Department of Medicine have a grievance or be dissatisfied with any aspect of the Program, he/she is encouraged to initially discuss the issue with his/her attending or the Chief Residents. If this is felt by the resident to be inappropriate or the issue is not satisfactorily resolved, timely discussion with the Program Directors is highly recommended.

In general, the resident will first discuss any grievance with the Chief Residents. If this fails to provide adequate closure to the grievance, then he/she is directed to speak with one of the Program Directors. Issues can best be resolved at this stage and every effort should be made to achieve a mutually agreeable solution.

In situations where the grievance relates to the Chair or Program Director, or where the resident believes that a fair resolution cannot be attained by presenting the grievance to those individuals, he/she may present the grievance in writing directly to the Office of Graduate Medical Education. The Associate Dean for Graduate Medical Education or an appropriate designee will meet with the resident, the Program Director, the Chair and one or more of the program’s Chief Residents to determine the cause and validity of the complaint and to determine the means of redress.

Should the meeting with the Associate Dean fail to resolve the grievance to the satisfaction of the resident, the resident may request that he/she be heard by the Executive Dean. Any action(s) taken in good faith by the Executive Dean addressing the grievance will be final.

III. Hospital and State Regulations

A. Kansas Licensure

A valid Kansas License is required before practicing medicine in this or any other hospital in Kansas. License application materials are sent to prospective interns soon after the match. For a temporary license, requirements include: graduation from an approved U.S. medical school (if an IMG, an approved foreign medical school, certification from the ECFMG and a valid visa); and supervised instruction in an approved training program. A temporary license (postgraduate permit) normally lasts for the duration of the residency (3 years). To convert to a permanent license, one must have passed Parts I, II and III of National Boards or FLEX and successfully completed a year of training in an approved program. Once a permanent license is provided, the postgraduate permit expires, and it is the resident’s responsibility to ensure that his or her permanent license is renewed yearly. Residents, who will be attending any Missouri-based institution, will need to obtain a Missouri license as well.

To continue in the Program, you must have a valid license. The program and the GME office track license expiration dates, but the Kansas Board of Healing Arts (KSBHA) ultimately views license renewal as the responsibility of the resident physician. In the event of failure to renew a temporary or permanent license before its expiration, the resident may be subject to discipline by the KSBHA, including fines and/or public censure. Materials can be provided by the Medical Education office, but you do have to fill these out expeditiously. The consequence of not having a valid license is immediate suspension from the Program until one is obtained.

B. BLS and ACLS

Basic life support and advanced cardiac life support is required of all residents. Certification only lasts for two years; you will have to renew your certification to stay current. The resident is responsible for getting this done in a timely manner.
C. Medicolegal Concerns

If you find yourself, a colleague, an attending or other professional person engaging in activities which may eventually be considered malpractice, it is your moral and legal responsibility to report this activity. You can approach another attending, one of the Program Directors, the Chief Residents, the risk management coordinator, a hospital ombudsman or the hospital lawyers. As a program, we strongly recommend that residents reach out to one of the above persons for the protection of themselves as well as other individuals involved.

Should you be contacted by a lawyer or paralegal for comments regarding a patient’s care, do not respond. Report the incident immediately to the Program Director’s office. The University and GME office have counsel available to handle any questions or concerns which arise.

You may be contacted by a representative of the hospital in the event that you were involved in the care of a patient with a complication or adverse outcome. KU Hospital and the VA Hospitals are committed to a culture of patient safety, and root cause analyses are performed when rare adverse events occur. The program encourages resident involvement in these investigations as part of the training experience and to prepare residents for independent practice. However, as a trainee you should always be accompanied by an attending physician or a program leader if you are to be interviewed about a patient care concern. Residents should let the chief residents know if they are contacted to participate in such an investigation.

On occasion, you may be contacted by the news media regarding the status of a patient admitted to the hospital. Do not answer any questions and report this to your attending, especially as a HIPPA violation may occur.

D. Ethics

With increasing medical sophistication, the ethical questions which surround a patient’s care often overwhelm the medical decisions. Ethical complexities are commonplace in the field of medicine. Even in the most complicated ethical situation, the first and most important step is to talk with the patient and family. Only through full communication with the appropriate decision maker can the resident address honestly, thoroughly and expeditiously the issues raised.

There are other people willing and able to assist. The chaplain service consists of full-time Protestant and Catholic ministers. (In addition, these ministers each lead Sunday services for hospital patients and employees). Other denominations have clergy on call to respond to patient requests.

The hospital ethics committee is available 24 hours per day by pager. The team consists of both medical and other supportive personnel who are available to explore and advise on major ethical concerns. Physicians on the committee are always available for discussion and for consultation. In addition, a monthly conference is held by the Ethics committee in conjunction with the General Medicine division. Ethical dilemmas arising on the inpatient medical services are discussed in an informal setting and lunch is provided.

E. Order Writing

All orders written on teaching service patients are placed by the residents after undergoing the appropriate EMR training.

The Program requires that all residents abide by the hospital’s order writing policies for physicians as outlined by the Pharmacy Department. It is the resident’s responsibility to ensure that his/her DEA license is up to date and that the number is provided to the pharmacy Department.

When concerns about a resident’s order writing competency are raised, order writing privileges might be suspended. This process requires that all orders be cosigned by staff before they are implemented. This is decided upon by the Program Director and his/her Assistant Program Directors and explicitly outlined for the resident in question before it takes effect.
IV. Department Rules/Understandings

There are rules, traditions, activities, and expectations of the Department of Medicine which may not apply to other departments at the Medical Center. The following is an attempt to introduce you to a few of the more important areas.

A. Policy for Supervision of Residents and Progressive Responsibility for Patient Care: please see also Appendix B, GME Supervision template

Inpatient Practice at KU Hospital, KCVA Hospital, and Leavenworth VA Hospital:

All patients are assigned to a responsible faculty physician, who supervises all resident care and personally sees the patient daily.

Attending rounds are held daily. At each practice site within our residency program, attending rounds encompass teaching rounds as well as clinical work rounds. The time and place may vary with each service and it is the resident’s responsibility to be at the right place at the right time. Attending rounds are a time for decision making regarding clinical and ethical problems with the patients, a time for teaching, and a time for the medical team to ask questions. Everyone on a service has responsibilities and duties without which the team cannot function effectively. In the event of an absence, the attending physician, the team and the IM Chief on call must be contacted.

In general, there are a number of responsibilities for each member of the inpatient medical team

R-1: It is the intern’s responsibility to know all the relevant clinical data for his/her patient. This includes, but is not limited to, vital signs, medications and dosages, physical exam findings, laboratory values, radiological studies, as well as pertinent family and social information. It is the intern’s responsibility to arrive at the hospital early enough each morning to see his/her patient’s before rounds and be able to present them in a succinct, thorough manner. It is also the intern’s responsibility to communicate updates to the family. When the intern does not know how to process certain clinical information, it is his/her responsibility to seek out superiors (senior resident or staff) for help. Interns are also expected to take call. The call schedule is assigned either by the senior resident on service or a Chief Resident.

R-2/3: It is the responsibility of the supervising resident to ensure that his/her team runs efficiently and provides the best care possible to the patients on the team. The senior resident is responsible for all of the patients on the team. He/she should see all of the newly admitted patients, the acutely ill patients, and the planned discharges before rounds. When an intern is absent from rounds for a day off, it is the senior resident’s responsibility to thoroughly evaluate the intern’s patients before rounds, be prepared to discuss these patients in detail, and write the progress notes. Senior residents are responsible for all aspects of supervision as it pertains to interns. Specifically, they are available to help with the interpretation of physical exam and laboratory findings and to guide R1s in use of system resources for discharge planning and coordination of care. It is their responsibility to communicate directly with both the attending physician as well as consulting physicians. They ensure that plans discussed during rounds are carried out effectively.

At the beginning of each week, the attending should orient the residents to his/her expectations. In addition, both the attending and the senior resident should review the rotational goals and objectives. Each attending will function somewhat differently; he/she will hold rounds in a different manner, will expect different levels of formality, will have different expectations for patient presentations and levels of decision making, and will consult other physicians to varying degrees. It behooves the resident to know the expectations of each attending. If this is not clear we encourage residents to ask.

Rounds on weekends usually vary from rounds during the week, becoming more service focused as the team accommodates the necessary days off for its members. Usually the attending or senior resident will decide on when rounds will be held.
If a resident must be absent (personal appointments, approved absences), it is his/her responsibility to inform the attending, senior resident, and chief resident in advance.

Generally, ward rounds are formal. It is expected that all members of the service will respect the patient and the person speaking with attention and appropriate response. Each resident is expected to look neat and well-groomed. T-shirts, shorts and athletic attire are not considered acceptable. Scrubs are permitted to be worn on weekends, and while rotating in an ICU.

**Handoffs and Evening and Night Coverage for Inpatient Services**

At all inpatient practice sites, residents are responsible for ensuring that they hand off their patients to their colleagues for nighttime coverage. These handoffs occur through a combination of documentation using a standardized template within the electronic medical record, and a face-to-face review of the documented information. Our program utilizes I-PASS which is an evidenced based handoff communication tool.

**Handoff Practice:**
All categorical residents are introduced to the i-PASS model of change-of-duty handoffs in our Friday School curriculum. All residents are asked to watch a short webinar explaining the concept of the i-PASS model along with its attributes and benefits prior to coming to class. In-class time is devoted to applying this knowledge with simulations. Multiple patient scenarios are introduced and residents pair up to take turns giving and receiving a handoff. During the pair-up activity, faculty directly observes the simulated handoffs and completes an Entrustable Professional Activity (EPA) to evaluate the resident. After each paired practice session, a short group discussion takes place where each pair shares their understanding of the patient and feedback about the handoff with the group as a whole.

**Handoff Performance:**
All residents are provided with pocket-sized reminder cards on the i-PASS Handoff model. Additionally, reminder cards are placed in the inpatient team rooms and on the mobile computers. Smart phrases have been created in the University of Kansas Electronic Medical Record (EMR) to help facilitate use of the i-PASS model as well. Intermittent reminders of the i-PASS model are provided throughout the academic year.

**Handoff Assessment:**
Assessment of each resident’s ability to perform a patient handoff is three-fold:

1. A simulated handoff between residents is supervised by a faculty member and evaluated using the directly supervised i-PASS Handoff EPA.
2. Anonymous peer evaluations of directly observed handoffs are completed throughout the year by resident colleagues who have received a handoff from that learner.
3. An *indirectly supervised* Handoff EPA is completed by faculty who evaluate the written handoff provided in the EMR and complete an EPA evaluation of their documentation.

It is expected that the night team member receiving check out has the opportunity to ask questions about each patient. The handoff of patients to the night float team occurs at a standard time and in a standard location. Additionally, the handoff from the night float team to the daytime team occurs at a standard time.

Inpatient services at KU and the KCVA are responsible for taking calls on and admitting patients to their own service until 7pm at night on weekdays. Inpatient teams can check out to the “short call” resident at 5pm. The team’s short call resident will remain in house until 7pm to take calls on their team’s patient and to admit patients to their team. Each individual team is responsible for determining the late day resident schedule. If the team’s late day resident is an intern, the short call senior resident is responsible for supervising admissions with the intern between the hours of 5pm to 7pm. At KU, interns are able to check out general medicine admissions directly to a direct care attending presuming clinical workload allows for this; if the direct care attending cannot receive checkout, the admission must be supervised by the medicine on duty (MOD) senior resident. On teams where there is only one resident and one intern, senior residents may take home call on their patients from 5pm-7pm; these teams’ admits after 5pm will be
the responsibility of the short call medicine on duty (MOD) senior resident. At the KCVA on weekdays, a separate Swing Senior is present from 4pm to 11pm to assist with admissions. Admissions performed by interns can be supervised by this Swing Senior or the MOD.

It is the responsibility of each resident to ensure safe transitions of care for their patients. To accomplish this, a formal checkout process will take place at 7pm each weekday evening. Residents expected to be present at these checkout sessions are the late day resident from each inpatient team, the senior short call resident, and the night float team. Checkout rounds will be held in a standardized location at each facility. The three senior residents (day MOD, night MOD, and Swing Senior) at checkout rounds are responsible for ensuring that an effective checkout process takes place.

As mentioned above, interns and upper level residents participate in a night float coverage system for the medicine inpatient wards at KU and the KCVA. Due to the night float coverage system, overnight call at KU and the KCVA is limited to one Sunday night call per rotation block for interns on inpatient services. Senior residents have no overnight call while on inpatient months at KU or the KCVA. Sunday night MOD shifts are covered by senior residents who are on consult experiences or electives.

The night float teams at KU and the KCVA are made up of an upper level resident and two interns; the night float team works Monday through Saturday and has Sunday nights off. The night float team comes on duty at 7pm and goes off duty at 8am. The night float team is responsible for all admissions and STAT consults to teaching medicine services (except those to the KU MICU and KU cardiology service) during their shift. The senior resident is involved in each admission/STAT consult while the interns alternate helping the senior resident with admits. The night float team is also responsible for all cross coverage responsibilities between 7pm and 8am. Interns take first call from nurses regarding questions or concerns on floor patients. Interns are expected to respond to calls from wards to assess patients who seem to be having problems. These calls have varying degrees of urgency and all requests to see patients should be taken seriously. Interns must respond to these calls expeditiously, and should often leave a note in the chart depending on the nature of the call and any action taken. The intern should have a very low threshold for calling the night float senior resident to review the case and the management plan. At KU, the senior resident is responsible for contacting either the private hospitalist in-house in the evening or the academic hospitalist on call to review and discuss management of admissions prior to midnight. At the VA, the senior resident is expected to check out evening admissions prior to midnight with the VA staff on call. Senior residents are to call and check out admissions that occur after midnight to the academic staff on call at both KU and the VA the next morning by 8 am.

To cover Sunday night shifts, inpatient interns may be scheduled to work a Sunday evening shift that begins at 7pm. Interns can expect one or two weekend calls per block. Inpatient interns will take cross cover calls as well as admit patients during this call. These interns will round with their inpatient teams the next morning and leave the hospital when their daily work is complete.

Inpatient senior residents are assigned a Saturday or Sunday daytime MOD shift one or two times per block; senior residents are responsible for all admissions and stat consults from 8am to 7pm on Saturday and Sunday. At the end of these shifts, the assigned upper level resident on that night will take over these responsibilities until 8am the following morning.

In the MICU and cardiology inpatient service at KU, night coverage is provided by a unit resident that is doing six consecutive twelve hour night shifts. In the MICU, these shifts begin at 6pm and end at 6am. In cardiology inpatient these shifts begin at 6pm and end at 6am. The night shift resident is responsible for all admissions to his/her respective team (up to the above defined ACGME admission limits) as well as taking all calls on unit patients. There is no short call in the MICU Monday-Friday. There is a short call system on weekends/holidays. Depending on how the day is going, residents not assigned to short call on weekends and holidays are permitted to leave at 2pm. The short call resident remains until 6pm and is responsible for all ICU admissions; they will check out the patients to the night float resident at 6pm. The team will provide check out to the assigned short call resident once rounds are finished and their work is done—but not before 2pm. This is not a hard and fast rule. There are often times in the unit where patient care requires all hands on deck for the entire shift. There is no short call on cardiology inpatient Monday-Friday. There is a short call system on weekends/holidays scheduled by the chief resident. The short call resident stays until 6pm and is responsible for all cardiology admissions; they will check out
the patients to the night float resident at 6pm.

At the Leavenworth VA hospital, one resident is chosen to represent both inpatient teams, and serve as the short call resident from 5pm until 6pm on Monday – Friday, at which time they will check-out to the in-house staff. On weekends, all residents stay and check out to the oncoming staff at 12pm. Residents are not responsible for overnight calls on their patients while rotating at the Leavenworth VA.

The senior resident on each general medicine team is responsible making the short call and team schedule regarding days off. Chief residents will assign intern and senior resident long calls and night float. Chief residents are responsible for making the short call schedule for MICU and cardiology inpatient teams at KU. Any changes to the chief-resident assigned schedule must be submitted in writing via QGenda and approved by the Chief Residents; appropriate admin staff will be notified so as to change the on call schedule.

Consultative Services at KU Hospital and the Kansas City VA Hospital

Consultative services will have different expectations as to when and where residents should be assigned to clinics and inpatient consults; the subspecialty education coordinator for each division will serve as the point of contact for resident physicians.

Ambulatory Care: Continuity Clinic Expectations and Lines of Responsibility

The Resident’s Continuity Clinic is the most consistent experience in ambulatory medicine. Residents may have their continuity clinic at KUMC, KCVA, Westwood Internal Medicine, with additional sites in development. Preliminary residents do not have continuity clinics.

The Resident’s Continuity Clinic is an opportunity for longitudinal relationships with patients, acting as their primary care physician. Residents follow a panel of patients for their entire three years of training. The emphasis is on creating an outpatient clinic environment replete with preventive medicine, follow up visits for chronic disease management, as well as acute care for episodic illnesses. Patients in the resident clinic will come from a variety of sources -- walk-ins with acute illnesses, patients followed by former residents, follow-ups from hospitalizations, etc.

Clinic templates are based on PGY level. Generally, PGY-1 residents will have maximum of 4 patients scheduled, and by the end of their intern year, up to 5 patients in a half-day clinic will be scheduled. PGY-2 residents will have up to 6 patients scheduled, and PGY-3 residents will have up to 7 patients scheduled in a half-day clinic. Generally, return patients are scheduled for 20 minutes, new patients for 40 minutes. All patients need to be checked out with the assigned clinic attending physician, who is ultimately responsible for the patient’s management at that visit.

The clinic attending will review each patient with the resident, to provide assistance in patient management decisions and are required to see all intern’s patients until he/she reaches his/her sixth month of training. Often times an attending physician will choose to continue seeing the resident’s patients if it is felt that the patients are complicated or acutely ill.

During the +1 ambulatory clinic week, each resident will have four continuity clinic sessions, one half-day session of quality improvement administrative and panel management time, one session for self-study and board review, one session for scheduled didactics, and 3 sessions of scheduled ambulatory subspecialty clinics or simulation. Residents will be given opportunities for experiences in allergy/immunology, dermatology, medical ophthalmology, office gynecology, sleep medicine, office orthopedics, and sports/rehabilitation medicine. Residents are also eligible to be granted protected half days for research/scholarly activities. Similar to elective experiences, this is contingent upon satisfactory ITE scores and a 60 day submission of the required paperwork, which is available on the residency website at the following link http://www.kumc.edu/school-of-medicine/internal-medicine/residency-program/program-initiatives/elective-rotations.html.
Exceptions to the 60 day rule can be made under extenuating circumstances on a case by case basis. Residents must complete all office visit notes and documentation within 48 hours of the office visit. This is to ensure timely visit completion based on clinic standards. Prior to rotating off of the +1 week, each resident must address all clinic and patient care correspondence paperwork. Ongoing panel management (responding to telephone messages, results, etc.) is expected throughout the three week inpatient block as well. Further, inbox management should occur at least every 72 hours. All inbox communication will be viewed by the resident’s assigned faculty preceptor and if urgent management is needed this will be communicated and completed by the faculty physician. Faculty preceptors will be first line of communication of the following rotations: night float, vacation, KU MICU, KU CCU, ER, and away electives. The resident needs to clearly communicate with his/her anchor nurse and faculty preceptor regarding upcoming rotations.

PGY 1 and 2 residents will be required to complete up to 3 PEAC modules each +1 week. These will be assigned and coordinated with the scheduled core curriculum. The modules are expected to be completed prior to noon on Friday of the +1 week. The modules are tracked by the program administrative staff. Faculty preceptors are expected to review the modules as well. Discussion of the topics, including additional instruction and clinical pearls will occur during the assigned continuity clinic time. PGY 3 residents will utilize 1 session per week during their +1 week to continue longitudinal board preparation.

Resident continuity clinic takes priority over other service obligations. As changes in clinic schedules impacts patient care, these changes must be made at least 60 days in advance, except in emergent situations. The logistics for making a change to a clinic schedule at KUMC is as follows:

1. Vacation requests are submitted to IM Chiefs via MedHub.
2. Requests are sent from IM Chiefs or bobbie fink to all involved parties.
3. Requests are approved or denied by the Medical Education Leadership Team.
4. Once approved, changes to the on-line schedule in Amion are made by the chief residents. IM Scheduling waits until this step is completed before canceling the clinic and rescheduling patients. Patients who cannot be rescheduled to their satisfaction may be routed to the clinic director or clinic nurse supervisor.
5. Cancellations made less than 60 days ahead of time constitute a “bump” and should be avoided if at all possible due to a resultant adverse impact on our patients.
6. Make-up clinics – If a resident is deficient on clinic numbers with regards to the target of 130 clinics over three years, then additional make up clinics may be required. These must be approved by the clinic director to ensure adequate exam rooms and nursing coverage.
7. If a resident takes vacation during their scheduled +1 ambulatory week, one make-up clinic will need to be coordinated on either the week preceding the leave or the week after the leave to comply with ACGME guidelines. This will be scheduled by the chief residents and communicated to the resident and covering staff via email. Changes will be reflected in QGenda.

When the schedule is created at the beginning of the academic year, vacations are included. However, if a change in vacation time is needed, the resident must fill out the necessary change of vacation form available on MedHub. Once completed and signed by the appropriate individuals, the change will be communicated to the scheduling staff to cancel the resident’s clinic, if the vacation will occur during the resident’s +1 week. If a vacation is to be taken during the +1 week, additional coordination between the resident, chief residents, ambulatory associate program director, and the clinic attending must occur to schedule a make-up clinic session to ensure that the resident will not be absent from their continuity clinic by more than 4 weeks. **Continuity clinics may be rescheduled for the following reasons:** Medical Education Conferences, Board Preparation Courses or USMLE/COMLEX Step 3, and Fellowship Interviews. **Continuity clinic can be cancelled with prior approval for the following reasons:** Medical Mission Trips/International Electives.
Residents whom have continuity clinic at the KCVA are expected to make changes to clinic >60 days out as well as the same rules apply for clinic make-up sessions for vacation during the +1 week. Communication regarding these changes should be directed to the clinic faculty preceptor, the IMChiefs@kumc.edu, and Dr. Stephanie Thompson. KCVA clinic changes are subject to approval by Dr. Thompson.

Residents whom have off site continuity clinics are expected to follow clinic cancellation guidelines of their practice site, with a minimum notice of 60 days, as well as the same rules apply for clinic make-up sessions for vacation during the +1 week. Residents are encouraged to investigate these guidelines prior to needing to use them to ensure that changes are made in line with standard clinic practice.

Most of the specialty services and many of the general medicine rotations at both KU and KCVA have outpatient clinics the resident will be expected to attend. This provides an excellent opportunity to see patients with specialty problems in an outpatient setting. In addition, required rotations in Neurology and Geriatrics include significant experience ambulatory experience. Between all the required clinics in general and specialty medicine, the resident will be spending at least one third of his/her residency in an ambulatory setting.

B. Clinical and Educational Work per Week

The Department of Medicine strictly enforces the ACGME’s expectations for the clinical experience as it relates to maximum hours of clinical and educational work per week.

As per the ACGME, clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. Residents should have eight hours off between scheduled clinical work and education periods. Additionally, residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments; at this time, there are no 24 hour shifts scheduled in our program.

Any potential violation of work hour requirements must be reported to the Chief Residents verbally at the time of the event so corrective action can be initiated. Residents are expected to report their work hours accurately. This must be done on a weekly basis, at minimum, in MedHub; reminder pages and emails will be sent by the administrative team to ensure that residents are aware of this responsibility and deadline. The program leadership, including the program director, reviews the report of each resident’s work hours weekly to ensure compliance and to address concerns immediately. In addition to a weekly review of clinical and educational work, the program director reviews this data on a monthly basis via MedHub. Finally, the program director receives a routine compliance report from GME related to programmatic clinical and educational work hour submissions and violations.

In MedHub, the following work hour categories with attached explanations are available:
Please notify the IMCHIEFS or administrative team if you have any questions or issues with the timely and accurate logging of duty hours.

As a back-up for any potential illnesses that occur while on service, for any need for scheduling changes in order to mitigate fatigue, for any unforeseen circumstances related to excessive admits/consults occurring during a planned shift, or for any additional extenuating circumstances, a jeopardy or “back-up” call system is in place with 2 interns and 2 senior residents. These calls are assigned and posted on the online “QGenda” scheduling website for viewing by residents and staff. A resident when on back-up call is expected to be carrying their pager at all times, as well as carrying a cell-phone for any unforeseen pager failure and to return pages. The resident should be available, within 1 hour, to be able to report to work if needed and to refrain from use of any substances including medications or alcohol which may lead to somnolence or inability to perform clinical duties if you are called upon. If a resident fails to respond to pages or phone calls when called upon for back-up or is unable/unwilling to report to work they will be assigned an additional week of back-up call and another overnight or MOD call as the chief residents see fit, and the situation will be discussed with the program leadership team.

C. Pagers

The training program will assign each resident a primary pager. Residents will be asked to carry additional pagers when on certain rotations. Replacement batteries are available at inpatient units in each hospital and in the Medical Education office.

Residents on consult services may be asked to cover or carry the call pager. Staff on call are always available to answer questions as well as see emergent consults. Responsibilities will vary depending on the particular service, but should never violate ACGME work hour requirements for on call duties.

D. Communication with referring physicians

Referrals are a large and very important part of the service provided by this Department to inpatients and outpatients. Patient transfers from outside of KUMC must be accepted by the attending physician. These referrals frequently come from physicians outside KU Medical Center, in the greater Kansas City area or outlying areas in Kansas and Missouri. Timely communication with referring doctors is essential. Referring physicians are conscientious practitioners who recognize a problem beyond their abilities and appropriately send the patient to this tertiary care center for further work-up and treatment. The resident should keep in mind that all communication with the Transfer Center should be directed to the attending physician on call. A resident cannot accept or deny a transfer.

It is appropriate to contact the referring doctor upon admission of the patient. This is to let the patient’s doctor know that his or her patient has arrived and to clarify any questions or priorities that may have arisen after the initial workup. It is also wise to contact the doctor periodically
during a prolonged admission to keep him/her updated. On discharge, the summary is faxed to the referring doctor; hence prompt dictation of summaries is essential to continuity of care.

If a resident’s primary care patient is admitted to the hospital either at KU or the KCVA, he or she should be notified via phone call, text page or email by the admitting service.

E. Special circumstances in regard to routine services, admission limits and covering non-teaching patients

At all sites where KUMC residents practice, there are no direct care service patients seen by residents except under urgent/emergent circumstances such as a Code Blue. Residents are not required to provide routine intravenous, phlebotomy, or messenger/transporter services, except in an emergency. Residents' service responsibilities are limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. (NOTE: “Teaching Service” is defined as those patients for whom internal medicine residents [PGY 1, 2, or 3] routinely provide care.)

F. Absences, notification, days off

It is unrealistic to expect that a resident will not become ill, not have personal emergencies, or not have other reasons to be absent. Should any of these occur, the resident’s first responsibilities are to:

1. Inform others on his/her team of the absence including supervising resident/fellow (if applicable) and attending physician.
2. Page the Chief Resident on-call.
3. Submit a sick day request through MedHub.

If deemed necessary by the chief residents in discussion with program leadership and the primary attending, the back up resident may need to be called in to cover. Prolonged absences, as from illness, require close communication with the Chief Resident as changes in schedules invariably must be made. If a resident is medically ill for 2 consecutive days or longer, he/she may be required to provide the Chief Residents with a doctor’s note to be placed in the resident’s file. Each resident is responsible for reporting any sick days used when he/she is filling out his time entry.

Anticipated days off should be cleared through the attending physician. If the resident will miss a clinic day, he/she needs to make their request to the Chief Residents. Planned absences should be scheduled at least 60 days in advance per clinic policy at all sites.

The Department recognizes the value of regular days off. Residents are guaranteed one day off a week averaged over four weeks. The details of arranging days off differ with each service -- generally the interns and residents arrange the schedule by themselves. If difficulties arise, discuss these with the attending and Chief Residents.

V. Benefits

Please see the GME policy and procedure manual for the most up to date benefit details specific to: stipend; health, dental and vision insurance; flexible spending and health savings account; professional liability insurance; worker’s compensation; meal cards; pagers; parking disability insurance.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

A. Parking

Parking is provided by the University of Kansas Health System in Garage 5 at KU. Parking at the Kansas City and Leavenworth VA Hospitals is also provided. It is important that residents park only in designated areas both at KU and our VA sites.

B. White coats

The University of Kansas Health System provides each resident with at least one white coat per year.
C. Access to Medical Literature and Board Preparation Materials

Access to the library’s electronic journals and databases are available online through the KUMC website, both on and off campus. All the University and KCVA hospital computers have Up To Date on them and internet access to the Dykes library is available. In addition, a number of board review resources are available for residents’ use in the chief residents’ office. The department provides each resident with a copy of the MKSAP board review materials as well.

D. Vacation

All House Staff are entitled to 15 days of vacation per year, to be taken in one-week blocks unless a special exception has been granted, and not to exceed two weeks in a row of absence. Vacations generally start on Mondays and finish on Sundays; the weekend off prior to the start of vacation is not guaranteed and will depend on the specific circumstances of any given rotation. Residents who make travel plans before obtaining approval from the program leadership are not guaranteed approval of the time away and may incur a financial loss for travel expenses.

There are certain rotations, such as ICU, inpatient cardiology, inpatient general medicine, emergency medicine, neurology, and geriatrics, during which vacations are not permitted. Each resident is allowed a maximum of 1 week vacation to be taken during their assigned +1 week each PGY year. Vacations during the +1 week will need coordinated and approved by the chief residents, ambulatory associate program director, and the clinic site director.

Under certain circumstances, requests can be granted for a change in vacation dates. These must go through the Chief Residents and be approved. As it relates to scheduled clinics, clinics may be cancelled by the chief residents if requests are made via email to IMCHIEFS greater than 60 days prior to the expected absence. Again, vacation taken during the +1 week will require make-up clinics and schedule coordination to ensure that the resident is not away from continuity clinic for greater than 4 weeks, exclusive of vacation. If changes are requested less than 60 days in advance they must be cleared by the designated clinic faculty as stated in the Leave Request Form on the internal medicine residency website. In this circumstance, once approved by this faculty member and the chief residents, the form will be forwarded to the appropriate contact persons and the resident is then expected to call all patients scheduled in his or her clinic and notify them of the cancellation. The patients should be directed to internal medicine scheduling to reschedule their appointment.

Preliminary residents or graduating residents starting fellowship or employment need to notify the chief residents at least three months in advance if they will be absent for orientation, travel, or moving at the end of the academic year. Vacation days will need to be saved during the year and applied for these absences.

National holidays are defined within the hospital in which the resident is working. Occasionally there is a discrepancy between holidays observed at KU and the Veterans Hospitals. There is no comparable time given for holidays at one hospital and not observed by the others.

E. Fitness Center

The Kirmayer Fitness Center, located on the corner of Rainbow and Olathe across from the Med Center, is open to all employees of the Med Center. The center has exercise equipment, aerobics rooms, a basketball court, racquetball courts, a circular track and a lap pool. Fees for residents are covered by the University of Kansas Health System.

F. ACP membership

The American College of Physicians was founded in the 1920s with the primary goal of providing and certifying continuing education for internists. Recognizing that residents and fellows are its future members and also have concerns different from the remainder of the membership, the ACP has a category termed Associate Member. Associates attend ACP meetings at a special price, order materials such as MKSAP at reduced cost, receive the Annals of Internal Medicine, are eligible for insurance and other benefits, sit on regional and national committees and, in fact, have most of the benefits of full membership short of voting at the annual meeting. The Department pays the dues for all categorical residents in bulk; the cost of these dues are subtracted from residents’ educational funds.
G. Sick Leave

The University will provide up to 10 workdays of sick leave per year to cover personal illness or illness in the resident’s immediate family (spouse or children). Sick leave cannot be accumulated from year to year.

As for any unplanned absence, the following steps must be followed by the resident physician:
1. Inform others on his/her team of the absence including supervising resident/fellow (if applicable) and attending physician.
2. Page the Chief Resident on-call.
3. Submit a sick day request through MedHub.

For any illness, which will require the resident to take a leave of absence, prompt notification to the Chief Residents and final approval by the Program Director must be obtained in writing. Should a leave of absence exceed accrued time, stipend payments will be interrupted. See GME Procedures Manual related to leave of absence for details.

The American Board of Internal Medicine allows up to one month, per year, as time away from the program. Time used beyond this one month will be required to be made up to meet the requirements for writing the Boards. The ABIM does not distinguish between vacation time or leave for illness, including pregnancy-related disabilities, and includes them as time away from the program.

H. Wellness Sessions

Each resident is provided two half day wellness sessions per academic semester to schedule self-care activities such as medical, mental health and dental care appointments. These are to be requested during the +1 week and must be requested at least 60 days in advance. Requests are sent to, evaluated, and approved by the IMChiefs as well as affiliate sites (if applicable). Wellness days cannot be scheduled during continuity clinics, Friday School, or simulation sessions. In the event that a resident has an entire day without a scheduled activity and he/she would like to utilize both half day sessions this can be requested and considered on a case by case basis. If an entire day absence is sought and approved, the resident must request a sick day in MedHub to account for the day. The +1 week following an emergency medicine rotation or associated with a geriatrics rotation is not eligible time for wellness sessions. All preliminary year residents are eligible for wellness sessions. These are offered as an entire single day experience. This will be communicated to their destination program and logged as a sick day in MedHub. All approved wellness days will be visible in QGenda.

The program has taken the initiative to schedule, and strongly encourage, all PGY-1 residents to meet with our Counseling and Educational Support Services clinic for a free/confidential wellness consultation. These wellness consultations will occur during a +1 week in lieu of a clinical experience. Should the resident “opt out” of the wellness consultation – they will be re-assigned to a clinical experience for that ½ day. A wellness session does not need to be utilized for this wellness consultation.

I. Leave of Absence – FMLA Leave and Non-FMLA Leave of Absence

It is important to inform the program of any need for long term leave so that appropriate planning can occur. Please see the GME Policy and Procedure Manual – http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html - related to the leave of absence policy – Section 5.5.13 FMLA Leave and 5.514 Non-FMLA Leave of Absence. As per above, the use of leave may require the resident to extend his/her training program as per ABIM requirements.

Per the ABIM website: “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. ABIM recognizes that leave policies vary from institution to institution and expects the program director to apply his/her local requirements within
these guidelines to ensure trainees have completed the requisite period of training.”

Elective time may be utilized for a non-clinical based rotation following the birth of a child. Residents are expected to meet with the chief residents and/or Program Director advisor to discuss the elective rotation as outlined previously in Section II. Residents are required to attend continuity clinics as well as podcast lectures during this time.

J. Moonlighting

The ability to moonlight with Departmental sanction is regulated by the Program Director and the Graduate Medical Education office. Moonlighting is not a right; it is a privilege. Residents must be in good standing and progressing steadily through the Department to be sanctioned to moonlight; residents on an educational prescription due to IM-ITE performance are not eligible to participate in moonlighting opportunities. Moonlighting must not conflict with the training assignment, call schedule, or patient responsibilities. In order to participate in moonlighting, residents must read and sign the policy sheet provided by the Department. All moonlighting hours are counted toward weekly work hours, which must not exceed 80 hours total. Residents with J-1 or H-1B visas are not eligible to moonlight. Please see the GME manual section 16 for comprehensive details regarding our institutional policy related to moonlighting: http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

K. Professional Leave

Up to five days of professional leave per year may be taken for interviews (job or fellowship), or to attend national and regional conferences and will not be counted as vacation time. If these professional days are needed during an inpatient rotational assignment, it is the responsibility of the resident physician to arrange inpatient team coverage. In order for leave for fellowship interviews to be considered for professional leave, the following steps must be completed:

- A W9 must be completed by the resident physician and returned to program administration for upload in the Travel Audit System; this pre-authorizes travel for worker’s compensation should an unfortunate event occur.
- Program administration must receive a travel itinerary from the resident physician including a copy of flight schedule (if applicable).

Professional leave must be requested and approved; it is not guaranteed depending on the clinical needs of the resident physician’s assigned rotation. Requests for professional leave beyond five days in a given year will need approval by the Program Director.

L. Scholarship / Educational Benefits and Funds

The following materials and memberships are purchased for categorical residents as they are deemed essential to each resident's educational development:

PGY1 Categorical Residents:
- MKSAP Complete (value $499)
- ACP Resident/Fellow Membership (value $119)
- ACP Board Prep Curriculum (per resident value $75)
- PEAC Curriculum (per resident value $30)

PGY2 Categorical Residents:
- ACP Resident/Fellow Membership (value $119)
- ACP Board Prep Curriculum (per resident value $75)
- PEAC Curriculum (per resident value $30)

PGY3 Categorical Residents:
- ACP Resident/Fellow Membership (value $119)
- ACP Board Prep Curriculum (per resident value $75)
- PEAC Curriculum (per resident value $30)
Preliminary year and categorical residents in good standing with the program have access to educational funds as follows:

PGY1 Preliminary Residents – Up to $1000 to be utilized as follows:
   A. Study materials for Step 3 or COMLEX 3.
   B. Test registration fee for Step 3 or COMLEX 3.
   C. Travel (air, lodging, meeting registration, local transportation) to a regional or national meeting in order to disseminate scholarship if attending as the presenting author.
   D. Costs associated with poster production and/or submission fees associated with dissemination of scholarship.
   E. Other educational books and/or resource with approval of the Program Director.
   F. Small medical equipment – such as additional white coats, on call jacket, stethoscope, ophthalmoscope or otoscope.

PGY1 Categorical Residents – Up to $1000 to be utilized as follows:
   A. Study materials for Step 3 or COMLEX 3.
   B. Test registration fee for Step 3 or COMLEX 3.
   C. Travel (air, lodging, meeting registration, local transportation) to a regional or national meeting in order to present scholarship if attending as the presenting author.
   D. Costs associated with poster production and/or submission fees associated with dissemination of scholarship.
   E. Other educational books and/or resource with approval of the Program Director.
   F. Small medical equipment – such as additional white coats, on call jacket, stethoscope, ophthalmoscope or otoscope.

PGY2 Residents – Up to $1250 to be utilized as follows:
   A. Travel (air, lodging, meeting registration, local transportation) to a regional or national meeting in order to present scholarship if attending as the presenting author.
   B. Costs associated with poster production and/or submission fees associated with dissemination of scholarship.
   C. Other educational books and/or resource with approval of the Program Director.
   D. Small medical equipment – such as additional white coats, on call jacket, stethoscope, ophthalmoscope or otoscope.
   E. Costs associated with renewal of BLS and/or ACLS.

PGY3 Residents – Up to $1250 to be utilized as follows:
   A. Travel (air, lodging, meeting registration, local transportation) to a regional or national meeting in order to present scholarship if attending as the presenting author.
   B. Costs associated with poster production and/or submission fees associated with dissemination of scholarship.
   C. Other educational books and/or resource with approval of the Program Director.
   D. Small medical equipment – such as additional white coats, on call jacket, stethoscope, ophthalmoscope or otoscope.
   E. Costs associated with renewal of BLS and/or ACLS.
   F. Registration for the ABIM certifying examination.

Additionally, PGY3 residents may access up to an additional $1500 in order to purchase board prep material or attend a board prep course. These additional monies may not be used for any other expenses.
Residents must be in good standing to access these funds. **All requests must be submitted in writing utilizing the standardized submission form with itemized receipts by May 1st of each academic year; requests submitted after May 1st of each academic year CANNOT be reimbursed due to departmental policies.** Reimbursement requests related to the dissemination of scholarship MUST include the citation for the work. Reimbursement requests will not be approved until this information is received. Examples –

**Poster presented at a national meeting:**

**Peer Reviewed article:**

All requests must be approved by the program director. **Funds do not roll over into the next academic year; again, the deadline for submission of requests for reimbursement is May 1st of each academic year. Requests submitted after May 1st of each academic year CANNOT be reimbursed due to departmental policies.** Medicine-psychiatry residents must request all monies through the medicine-psychiatry program director or his/her designee.

**VI. Other**

**A. Housestaff recruitment**

The process by which House Staff are selected, involves all members of the Department. The invited applicant’s interview day is designed to provide potential interns the widest possible exposure to our Department. Attendance of conference, orientation by the Chief Residents, meetings with residents over lunch and faculty interviews comprise a full morning for applicants.

One of the most important aspects of the interview day is the applicant’s interaction with our residents. We are proud to showcase our program and feel that it is very important that the candidates meet our residents. We feel that the residents are the most instrumental part in the Department’s recruiting drive.

Potential incoming interns are our resident’s future colleagues. It is critical that any feedback our residents may have be conveyed to the Chief Residents or the Program Director/other members of the medical education leadership team. Recruitment season is time-consuming but essential to continue the long tradition of exemplary residents in internal medicine.

Our resident’s appraisal of the applicant, along with our faculty’s impressions and assessments, combined with the applicant’s letters of recommendation, medical school dean’s letter, and personal statement makes up the file for each applicant. All files are carefully reviewed by all members of the medical education leadership team, and a match list is compiled for the computerized national match of R-1’s.

**B. Fellowships**

Traditionally about 60% of the residents have gone on to complete subspecialty fellowships. Graduates of the program have been very successful in attaining positions in this Department as well as at the most competitive programs in the country. Interviewing for fellowships usually begins in the fall of the R3 year. While the interview season is an exciting time, it can be difficult to juggle demands of a service with the need to interview. In general, fellowship interviews are held in September, October, and November. Residents are encouraged to plan their vacation time around the months they are likely to interview; you may also use regularly scheduled days off for interviews. Once interview dates are confirmed, it is the interviewee’s responsibility to coordinate service coverage while he/she is away to interview. Please see additional details above outlining professional leave expectations.
C. Verification of Training

One of the key functions of the office of Medical Education is verification of training for past graduates. After residents complete their training, files are maintained indefinitely to document the length and content of their training as well as their performance. The Medical Education office is responsible for completion of forms documenting training as residents apply for hospital credentials, state medical licenses, etc. Residents should ensure that the Medical Education office has updated contact information, including business address, e-mail, and phone numbers so that future communication can be maintained.
Appendix A: ACGME Reporting Milestones

Resident Milestone Evaluation - Internal Medicine

Program Name - Internal medicine

Resident
Name:  
Year in
Program:
Position
Type:  
Start
Date:
Expected
End Date:

Select the option corresponding to the resident's performance in each area below. Your selections should be based on the longitudinal or developmental experience of the resident. Milestone levels do not correspond to the resident's year in your program. Evaluation must be based on observable behavior. Mouse over the radio buttons to read the criteria for each developmental level.

There may be cases in which a resident had no experiences or education within an individual competency area during the previous six months. This could be because a resident did not have a rotation addressing that area, or recently returned from a leave of absence. In these cases, the reported milestone level should remain the same as the one reported during the previous evaluation. Do not increase (or decrease) the milestone level simply because time has passed; an evaluation of each competency area must occur every six months. To review previously completed milestone evaluations, go to the ‘Reports’ tab in ADS and select “Milestone Evaluations”.

Evaluation to be completed:

### Patient Care

<table>
<thead>
<tr>
<th>a) Gathers and synthesizes essential and accurate information to define each patient’s clinical problem(s)</th>
<th>Not Yet Assessed</th>
<th>Critical Deficiencies</th>
<th>Ready for Unsupervised Practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Develops and achieves comprehensive management plan for each patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Manages patients with progressive responsibility and independence</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d) Skill in performing procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Requests and provides consultative care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Yes  No  Marginal
Medical Knowledge

<table>
<thead>
<tr>
<th></th>
<th>Not Yet Assessed</th>
<th>Critical Deficiencies</th>
<th>Ready for Unsupervised Practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Clinical knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Knowledge of diagnostic testing and procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Systems-Based Practice

<table>
<thead>
<tr>
<th></th>
<th>Not Yet Assessed</th>
<th>Critical Deficiencies</th>
<th>Ready for Unsupervised Practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Works effectively within an interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and other support personnel)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Recognizes system error and advocates for system improvement</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>c) Identifies forces that impact the cost of health care, and advocates for, and practices cost-effective care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Transitions patients effectively within and across health delivery systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Practice-Based Learning and Improvement

<table>
<thead>
<tr>
<th></th>
<th>Not Yet Assessed</th>
<th>Critical Deficiencies</th>
<th>Ready for Unsupervised Practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Monitors practice with a goal for improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Learns and improves via performance audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Learns and improves via feedback</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Learns and improves at the point of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>a) Has professional and respectful interactions with patients, caregivers and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel)</th>
<th>Not Yet Assessed</th>
<th>Critical Deficiencies</th>
<th>Ready for Unsupervised Practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>b)</td>
<td>Accepts responsibility and follows through on tasks.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td>Responds to each patient’s unique characteristics and needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td>Exhibits integrity and ethical behavior in professional conduct</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Yes  No  Marginal

### Interpersonal and Communication Skills

<table>
<thead>
<tr>
<th>a) Communicates effectively with patients and caregivers</th>
<th>Not Yet Assessed</th>
<th>Critical Deficiencies</th>
<th>Ready for Unsupervised Practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Communicates effectively in interprofessional teams (e.g. peers, consultants, nursing, ancillary professionals and other support)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Appropriate utilization and completion of health records</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Yes  No  Marginal
**Overall Clinical Competence**

This rating represents the assessment of the resident's development of overall clinical competence during this year of training:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Superior</strong></td>
<td>Far exceeds the expected level of development for this year of training</td>
</tr>
<tr>
<td><strong>Satisfactory</strong></td>
<td>Always meets and occasionally exceeds the expected level of development for this year of training</td>
</tr>
<tr>
<td><strong>Conditional on Improvement</strong></td>
<td>Meets some developmental milestones but occasionally falls short of the expected level of development for this year of training. An improvement plan is in place to facilitate achievement of competence appropriate to the level of training</td>
</tr>
<tr>
<td><strong>Unsatisfactory</strong></td>
<td>Consistently falls short of the expected level of development for this year of training</td>
</tr>
</tbody>
</table>

For any comments, concerns or suggestions about Milestone Evaluations, contact us.

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Appendix B: GMEC Resident Supervision Template

A. Supervision of Residents

- Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by each Review Committee) who is responsible and accountable for that patient’s care.
- This information must be available to residents, faculty members, other members of the health care team, and patients.
  - Inpatient: Patient information sheet included in the admission packet and listed on the “white board” in each patient room
  - Outpatient: Provided during introduction verbally by residents and/or faculty
- Residents and faculty members must inform patients of their respective roles in each patient’s care when providing direct patient care.
- The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

B. Methods of Supervision

- Supervision may be exercised through a variety of methods.
- For many aspects of patient care, the supervising physician may be a more advanced resident or fellow.
- Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow or senior resident physician, and either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback.
- The program must demonstrate that the appropriate level of supervision is in place for all residents is based on each resident’s level of training and ability, as well as patient complexity and acuity.
- Supervision may be exercised through a variety of methods, as appropriate to the situation.
- The Review Committee may specify which activities require different levels of supervision.

C. Levels of Supervision Defined

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

Direct Supervision:
- The supervising physician is physically present with the resident and patient.

Indirect Supervision A (with direct supervision immediately available):
- The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

Indirect Supervision B (with direct supervision available):
- The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight:
- The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and as supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
<table>
<thead>
<tr>
<th>Per Program Specific RRC Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RRC APPROVED LICENSED INDEPENDENT PRACTITIONER SUPERVISOR</strong> and this information must be available to the residents, faculty members, other members of the health care team and patients. (PR VI.A.2.a (1))</td>
</tr>
</tbody>
</table>

Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient’s care.

Information regarding licensure for attending physicians is available via a publicly available database: [http://docfinder.docboard.org/ks/df/kssearch.htm](http://docfinder.docboard.org/ks/df/kssearch.htm)

Licensure data on resident physicians is kept up to date in the University of Kansas Health System GME Office.

**VI.A.2.a). (1).(b.) Inform each patient of their respective roles in patient care, when providing direct patient care.**

This information must be available to residents, faculty members, other members of the health care team, and patients.

Inpatient: Patient information sheet included in the admission packet and listed on the “white board” in each patient room. Provided during introduction verbally by residents and/or faculty.

Outpatient: Communicated to patient at time of appointing scheduling. Provided during introduction verbally by residents and/or faculty.

**PGY – 1 residents must be supervised either directly or indirectly with direct supervision immediately available. Conditions and the achieved competencies under which a PGY -1 resident progresses to be supervised indirectly with direct supervision available: (PR VI.A.2.e.(1).(a)**

Guidelines for circumstances and events in which residents must communicate with their supervising faculty member are delineated in the Housestaff Manual and in the rotational goals and objectives. PGY-1 residents are supervised, either directly or indirectly with direct supervision immediately available on site, by PGY-2 or PGY-3 residents or staff members on all rotations, including night float, at all training sites. During daytime inpatient, consult, and outpatient rotations, supervision is direct and occurs by an attending physician as well as a senior resident. On night float rotation at KU Hospital, a senior resident and a hospitalist faculty attending are present on location to immediately provide direct supervision. On night float rotation at Kansas City VA Hospital, a senior resident is present on location to immediately provide direct supervision and a faculty attending is available by pager and is available to provide Direct Supervision. Residents are not responsible for nighttime coverage at the Leavenworth VA Hospital.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and faculty members. (PR VI.A.2.d, (1,2,3))

The program has adapted the American Board of Internal Medicine’s Milestones of Competency to delineate our overall and rotational goals and objectives. Our evaluation system provides data on the ACGME reporting milestones. This data along with review of the resident’s portfolio of work allows the Program Director and faculty members to make determinations on a resident’s ability to gain progressive authority and responsibility.

The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones.

Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.

Senior residents or fellows serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each
patient and the skills of the individual resident or fellow.

### RARE CIRCUMSTANCES WHEN RESIDENTS may elect to stay or return to the clinical site: (PR VI.F)

In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

- to continue to provide care to a single severely ill or unstable patient;
- to attend to humanistic attention to the needs of a patient or family; or,
- to attend unique educational events.

The program monitors circumstances in which residents stay beyond scheduled periods of duty through the institutional work hours monitoring system in MedHub. The program leadership reviews the resident work hours report weekly, and residents are instructed to enter a comment in their work hours report indicating the reason for their work hours violation. In addition, the chief residents contact all residents with reported work hours violations to inquire about the cause and impact of the violation. This data is reviewed and discussed during weekly program leadership meeting, and trends are carefully sought and addressed.

### DEFINED MAXIMUM NUMBER OF CONSECUTIVE WEEKS OF NIGHT FLOAT AND MAXIMUM NUMBER OF MONTHS PER YEAR OF IN-HOUSE NIGHT FLOAT (PR VI.F. 6.)

**Maximum Frequency of In-House Night Float**

Residents must not be scheduled for more than six consecutive nights of night float.

**VI.G.7. Maximum In-House On-Call Frequency**

- PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four week period).
- VI.G.7.a) Internal Medicine residency programs must not average in-house call over a four-week period.

All call for the program occurs on a night float schedule except for Sunday night intern call on inpatient services, which is a 16-hour shift performed on a rotation about once to twice per month per intern.

### Program-specific guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty (PR VI.A.2.e)

1. Admission to Hospital
2. Transfer of patient to a higher level of care
3. Clinical deterioration, especially if unexpected
4. End-of-life decisions
5. Change in code status
6. Red Events
7. Change in plan of care, unplanned emergent surgery or planned procedure that does not occur
8. Procedural complication
9. Unexpected patient death
RED EVENTS - DEATH AND SERIOUS INJURY AND/OR NEAR MISS

- Serious blood transfusion reaction
- Contaminated drug, device or biologic
- Equipment related injury
- Falls resulting in major injury
- Fire, flame, smoke or heat during patient care
- Electric shock or burn during patient care
- Infection: Patient to patient and or visitor exposure
- Maternal/Perinatal
  - Unexpected peri-natal death
  - Unexpected infant death
  - Unexpected maternal death or serious disability
- Medication error with serious injury and/or death
- Eloement of patient lacking capacity, danger to self or others, or involuntarily admitted
- Radiation overdose
- Restraint or bedrail use causing death or serious injury
- Serious iatrogenic injury
- Unexpected deaths in ambulatory settings (excluding Emergency Department)

- Procedural and perioperative events
  - Procedure performed on wrong body part or wrong patient
  - Wrong procedure performed
  - Unexpected intraoperative/postoperative death
  - Death during elective surgery or procedure
  - Unintentionally retained foreign object
  - Wrong donor sperm or egg
- Security:
  - Disruptive behavior that causes harm or injury to patient or impedes patient care
  - Sexual assault or rape of a patient, visitor or employee
  - Infant discharged to the wrong family
  - Impersonation of a health care professional
  - Patient abduction
- Suicide/Homicide of patient, employee, visitor on health system premises campus
- Any defect that has the potential to cause harm across the health system
## PGY 1

<table>
<thead>
<tr>
<th>LEVEL of SUPERVISION</th>
<th>ACTIVITIES /PROCEDURES (as defined by RRC &amp; Program)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIRECT</strong></td>
<td>ACLS&lt;br&gt;Arterial blood draw&lt;br&gt;Arterial line&lt;br&gt;Arthrocentesis&lt;br&gt;Bone marrow aspiration&lt;br&gt;Bone marrow biopsy&lt;br&gt;Bronchoscopy&lt;br&gt;Cardioversion&lt;br&gt;Chest tube placement&lt;br&gt;Intubation, elective&lt;br&gt;Intubation, emergent&lt;br&gt;Laryngeal mask airway&lt;br&gt;Lumbar puncture&lt;br&gt;Nasogastric tube placement&lt;br&gt;Pap smear (until at least one performed)&lt;br&gt;Paracentesis&lt;br&gt;Thoracentesis&lt;br&gt;Ultrasound for central line placement</td>
</tr>
<tr>
<td><strong>INDIRECT A</strong> (with direct supervision immediately available)</td>
<td>Electrocardiogram interpretation (preliminary interpretation)&lt;br&gt;Periphereal IV&lt;br&gt;Radiology interpretation (preliminary interpretation)&lt;br&gt;Venous blood draw</td>
</tr>
<tr>
<td><strong>INDIRECT B</strong> (with direct supervision available-as determined by program specific RRC guidelines PR VI.D.5.a).(1))</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>ALL OTHER RESIDENTS</strong></td>
<td>Bone marrow aspiration&lt;br&gt;Bone marrow biopsy&lt;br&gt;Bronchoscopy&lt;br&gt;Cardioversion&lt;br&gt;Chest tube placement&lt;br&gt;Intubation, elective&lt;br&gt;Intubation, emergent&lt;br&gt;Laryngeal mask airway</td>
</tr>
<tr>
<td><strong>DIRECT</strong></td>
<td>ACLS&lt;br&gt;Electrocardiogram interpretation&lt;br&gt;Incision and drainage of an abscess&lt;br&gt;Nasogastric tube placement&lt;br&gt;Pap smear&lt;br&gt;Periphereal IV&lt;br&gt;Radiology interpretation&lt;br&gt;Venous blood draw</td>
</tr>
<tr>
<td><strong>INDIRECT A</strong> (with direct supervision immediately available)</td>
<td>Electrocardiogram interpretation&lt;br&gt;Incision and drainage of an abscess&lt;br&gt;Nasogastric tube placement&lt;br&gt;Pap smear&lt;br&gt;Periphereal IV&lt;br&gt;Radiology interpretation&lt;br&gt;Venous blood draw</td>
</tr>
</tbody>
</table>

Each of the procedures below can be performed with Indirect supervision with direct supervision immediately available provided that quantitative and qualitative assessment metrics have been met AND...
that procedural certification supervision requirements have been updated in Medhub by the program director:
Arterial blood draw
Arterial line placement Arthrocentesis
Central venous line placement
Lumbar puncture
Paracentesis
Thoracentesis
Ultrasound for central line placement

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Supervision Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial blood draw</td>
<td>INDIRECT B</td>
</tr>
<tr>
<td>Arterial line placement Arthrocentesis</td>
<td>N/A</td>
</tr>
<tr>
<td>Central venous line placement</td>
<td>INDIRECT B</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>N/A</td>
</tr>
<tr>
<td>Paracentesis</td>
<td>INDIRECT B</td>
</tr>
<tr>
<td>Thoracentesis</td>
<td>N/A</td>
</tr>
<tr>
<td>Ultrasound for central line placement</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Appendix C: ACGME Clinical and Educational Work per Week

Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Clinical Work and Education
The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.

Residents should have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Clinical Work and Education Period Length
Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.

Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions
In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

(1) to continue to provide care to a single severely ill or unstable patient; (Detail)
(2) humanistic attention to the needs of a patient or family; or, (Detail)
(3) to attend unique educational events. (Detail)

These additional hours of care or education will be counted toward the 80-hour weekly limit.

The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the residents’ work week.
Appendix D: Clinical Competency Committee

1. Appointments to the Clinical Competency Committee (CCC) are made by the program director.
2. Members: Program director, associate program directors (4), core faculty (7).
3. Responsibilities of the Clinical Competency Committee:
   a. Review all resident evaluations semi-annually.
   b. Prepare and assure the reporting of Milestones evaluations of each resident semi-annually to the ACGME.
   c. Advise the program director regarding resident progress, including promotion, remediation and dismissal.
   d. Given the sensitive nature of the resident review process, all members of the CCC will be expected to maintain the highest standards of confidentiality as part of participation on the CCC.

2018-2019 Members:
- Leigh M. Eck, Program Director
- John Bonino, Associate Program Director
- Jane Broxterman, Associate Program Director, Chair
- Becky Lowry, Associate Program Director
- Laura Thomas, Associate Program Director
- Abebe Abebe, Core Faculty
- Marie Brubacher, Core Faculty
- Erica Howe, Core Faculty
- Jessica Kalendar-Rich, Core Faculty
- Jessica Newman, Core Faculty
- David Naylor, Core Faculty
- Matt Sharpe, Core Faculty

Semiannual Resident Evaluation Process
- The CCC will meet on a semi-annual basis in November/December and in May/June to review all resident evaluations; meetings will be held weekly until all semi-annual reporting work is done.
- Members of the CCC will each review and prepare for presentation of their advisees at each semi-annual evaluation meeting. Preparation for resident presentation will include review of all evaluations by all evaluators available for that resident including but not limited to:
  - Faculty Evaluations of the Resident
  - 360 Evaluations of the Resident (Peer, Self, Nurse, Medical Student, Patient)
  - Continuity Clinic Evaluations
  - Conference Evaluations
  - Any applicable program director correspondence
- A packet containing all evaluations will be prepared by the Residency Coordinator at least one week before the CCC meeting.
- A form for a structured review of all evaluations will be utilized for use as a template for resident presentation.
- Preparation before CCC Reporting Meetings
  - Core Faculty (CF) completes 22 NAS Reporting Milestones (NAS RM) on his/her resident panel and sends to appropriate PD/APD (PDs)
  - PDs complete 22 NAS RM on his/her resident panel and compare to CFs report
  - CFs and PDs discuss any discrepant scores and create a ‘Discussion List’ of residents who need to be on Master Discussion List for the CCC Reporting Meeting
- Reasons For Discussion or placement on Master Discussion List
  - Any Evaluation Score ≤ 2.0 on any of 22 NAS RM
  - ITE ≤ 30%
  - Any ‘Marginal’ or ‘No’ on the competency trajectory questions
  - Chief Resident Concern
• Advisor concern
  o Residents that are progressing without concern will be placed on a consent agenda; any committee member can request that a resident be moved from the consent agenda to the Master Discussion List
  • At the CCC meeting, each resident will be discussed – either by way of consent agenda or master discussion list. Faculty members are expected to be available for the entire review session.
  • Dates for the CCC meetings will be determined at least 6 months in advance as faculty attendance is mandatory for all assigned CCC semi-annual evaluation meetings.
  • If absence from the scheduled CCC is unavoidable, the faculty member will be expected to complete the resident review prior to the meeting so that the other resident advisor can present the resident to the CCC.

ACGME Reporting
• The CCC will complete the ACGME required Milestone reporting during the resident evaluation review.
  o When there is clear agreement regarding milestone assignment, the milestones will be reported as recommended by the presenting faculty member.
  o When there is not clear agreement on milestone assignment, the CCC will come to a consensus on the milestone level to be reported.
• The final reporting of each milestone will be approved by the CCC prior to submission to the ACGME.

Advisory Role
• If concerns arise regarding resident performance during the CCC meetings, the CCC will make recommendations regarding any and all forms of remediation to the program director. The program leadership will be responsible for developing individual remediation plans based on these recommendations.
• The CCC will be responsible for determining what milestone level achievement will be required for residents to be promoted to the supervisory level. These standards will be reviewed on a yearly basis or more often in light of recommendations from national organizations studying these standards.
• The CCC will be responsible for determining what milestone level achievement will be required for successful completion of residency. These standards will be reviewed on a yearly basis or more often in light of recommendations from national organizations studying these standards.
• Supplemental meetings
  o The CCC will meet on a monthly basis to review ongoing activities of the residency program.
  o Given that high stakes decisions such as promotion may not be possible after only 5 months of residency training, an additional meeting of the CCC may be held in mid-February in order to make determinations regarding promotion to the supervisory level prior to the March 1st deadline for all decisions regarding non-promotion.
  o Additional meeting will be held in mid-February for any senior resident with marginal status the previous semester.
Appendix E: Program Evaluation Committee

1. Appointments to the Program Evaluation Committee (PEC) are made by the program director.
2. Members: Program director, associate program directors, chief residents, core faculty, site directors, resident liaison committee members – peer selected resident members.

2018-2019 Members:
Leigh M. Eck, Program Director
John Bonino, Associate Program Director
Jane Broxterman, Associate Program Director
Becky Lowry, Associate Program Director
Laura Thomas, Associate Program Director
Kyle Jansson, Chief Resident
Amanda Jones, Chief Resident
Zachary Lauer, Chief Resident
Ben Quick, Chief Resident
Christopher Streiler, Chief Resident
Abebe Abebe, Core Faculty
Marie Brubacher, Core Faculty
Erica Howe, Core Faculty
Jessica Kalendar-Rich, Core Faculty
Jessica Newman, Core Faculty
David Naylor, Core Faculty
Matt Sharpe, Core Faculty
Vinutha Kumar, Site Director
Fatima Khan, Site Director
Resident Liaison Committee Members – peer elected on an annual basis

3. Goal: The PEC’s primary goal is the administration and maintenance of an educational program that produces competent physicians capable of practicing independently without supervision at the end of training.

4. Responsibilities of the Program Evaluation Committee:
   a. Plan, develop, implement, and evaluate educational activities of the program.
   b. Review and make recommendations for revision of competency-based curriculum goals and objectives.
   c. Address area of non-compliance with ACGME standards.
   d. Review the program annually using evaluations of faculty, residents and others.
   e. Document a formal, systematic evaluation of the curriculum at least annually.
   f. Render a written Annual Program Evaluation.
   g. Monitor and track each of the following:
      i. Resident performance.
      ii. Faculty development.
      iii. Graduate performance including performance on the ABIM-CE.
      iv. Program quality.
      v. Review of resident annual evaluation of the program.
      vi. Review of faculty annual evaluation of the program.
      vii. Progress on the previous year’s action plan.
      viii. Retention of qualified residents.
   h. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas above, as well as delineate how they will be measured and monitored.
      i. The PEC, with guidance from the central KU GME office, will document a formal, systematic evaluation of the curriculum and render a written APE due annually in September.
ii. The written APE will document action plans to improve resident performance, faculty development, graduate performance, and program quality, as well as delineate how they will be measured and monitored.

iii. The APE will review and update the status of the previous year’s action plans and identify new action plans for the upcoming year as appropriate.

iv. The APE, including all action plans, will be reviewed and approved by the PEC and documented in meeting minutes.

v. The APE will be tethered to Major Program Changes in WebADS and Program AIMS if applicable.

vi. The program director will use the PEC feedback to inform the completion of the Annual WebADS update.