



THE UNIVERSITY OF KANSAS INTERNAL MEDICINE RESIDENCY POLICY AND PROCEDURES MANUAL

REVISED JANURARY 29, 2024

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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.

The accomplishment for which the Department is most proud is the character and quality of its graduates. Throughout the Midwest, the quality of our training program is recognized by hospitals and medical groups, making our graduates highly sought after; our department takes great pride in training highly skilled internists.

The Internal Medicine Residency training program is a subset of the Graduate Medical Education department at the University of Kansas Medical Center. As a program, we adhere to the policies and procedures established by their collaboration with the university, health center, ACGME, and ABIM.

For institutional GME policies, please refer to the GME Policy and procedures manual located here:

[HTTPS://WWW.KUMC.EDU/DOCUMENTS/GME/KUSOM-GME-POLICY-AND-PROCEDURE-MANUAL.PDF](https://www.kumc.edu/Documents/GME/KUSOM-GME-POLICY-AND-PROCEDURE-MANUAL.PDF)

For ACGME program requirements, please refer to the manual at link below

[HTTPS://WWW.ACGME.ORG/GLOBALASSETS/PFASSETS/PROGRAMREQUIREMENTS/140_INTERNALMEDICINE_2023.PDF](https://www.acgme.org/globalassets/pfassets/programrequirements/140_internalmedicine_2023.pdf)

MISSION AND AIMS

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 care 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 mission of our program is to provide our resident physicians with excellent clinical and scientific training allowing them to excel across all core Internal Medicine competencies. Beyond clinical readiness for practice and/or fellowship training, it is our goal to cultivate our residents' innate desire to ask questions and to seek scientific answers. Furthermore, we aim for each of our residents to understand their personality strengths, empowering them to possess the confidence and centeredness to be dynamic, humble, and empathetic team leaders who are positioned to seek exceptional opportunities in their professional lives.

To this aim the Program seeks to:

1. Achieve excellence in recruitment by prioritizing a selection of diverse individuals with outstanding communication skills, a strong aptitude, an empathic personality, and an innate scientific curiosity.
2. Provide a rotational framework that ensures a high level of competency in all areas of Internal Medicine, but still allows for an individualized educational plan for each of our residents.

3. Assure diverse clinical experiences in the outpatient and inpatient environments, where resident learning is a priority and faculty are supported and equipped to help residents achieve their potential.
4. Deliver an innovative curriculum with emphasis on active, simulated, and experiential learning environments that positions our program to exceed the national average for the American Board of Internal Medicine Certifying Exam three year rolling first attempt pass rate.
5. Develop a cohort of physician scientists who embody the research mission of our department and institution.
6. Utilize well-being consults and coaching to ensure that our resident physicians are able to recognize the benefits of proactive psychological support to optimize physician performance and to best serve our patients.
7. Cultivate an environment within our residency program that fosters respect and kindness towards others and offers support and encouragement in all situations.
8. In collaboration with The University of Kansas Health System and our affiliate sites, deliver a robust longitudinal experiential Quality Improvement and Patient Safety curriculum ensuring that our residents are exposed to institutional quality and safety practices so that they may be future leaders in this space.

PROGRAM DESCRIPTION

EVALUATION AND FEEDBACK

ACGME MILESTONES AND CORE COMPETENCIES

The Department of Internal Medicine utilizes the ACGME milestone-based performance criteria for the advancement/promotion of its residents. These milestones serve as the basis for performance expectations, evaluation of residents, and as a tool for reports submitted to the ACGME and the ABIM.

[HTTPS://WWW.ACGME.ORG/GLOBALASSETS/PDFS/MILESTONES/INTERNALMEDICINEMILESTONES.PDF](https://www.acgme.org/globalassets/pdfs/milestones/internalmedicine_milestones.pdf)

Residents are evaluated on each rotation in the six competencies by his/her attending physician by means of electronic evaluations. The program also seeks feedback in a 360-degree evaluation structure with the goal of achieving a multi-source evaluation of the resident's work and communication skills.

Multi-Source Evaluation Process
Self
Faculty
Medical Students
Resident Peers
Patients
Nursing/Ancillary Medical Personnel

In addition to rotational evaluations, each resident is assigned two faculty advisors: a program director and a core faculty. The resident's program director advisor and core faculty advisor regularly review 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 reporting milestones. Annually, reports on resident performance are submitted to the American Board of Internal Medicine.

ACGME COMPETENCIES

The criteria for advancement and final matriculation from the residency program are based upon the satisfactory achievement of the Competencies as outlined by the American College of Graduate Medical Education (ACGME). The ACGME Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty. The competencies can be found here – pages 28 through 34:

https://www.acgme.org/globalassets/pfassets/programrequirements/140_internalmedicine_2023.pdf

Before graduation a resident must have achieved these ACGME competencies, be deemed competent to act independently as a professional internist based on the ACGME reporting milestones. He/she should exhibit leadership, refined management skills, cooperation with colleagues, and an appreciation for the community in which he/she practices medicine.

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:

1. Complete the requisite predoctoral medical education
2. Meet the training requirements
3. Meet the licensure requirements and procedural requirements
4. 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. Please visit the ABIM website for board eligibility requirements. [HTTPS://WWW.ABIM.ORG/](https://www.abim.org/)

INTERNAL MEDICINE IN TRAINING EXAM

The Department requires the Internal Medicine In-Training Examination be taken by all categorical residents, each year, as a means of self-assessment. Results from this test are 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 director 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 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 entered into a formal mentored board preparation program. This program includes the following:

1. Formal learning style assessment
2. Required meeting(s) with GME based educational support services
3. Timely preparation and completion of Step 3 or Complex 3
4. Written board preparation plan—updated semi-annually at time of the semi-annual review
5. 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
6. Scheduling consideration for subspecialty areas of identified weakness based on ITE performance and elective requests
7. 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-ITE.

CLINICAL TRAINING SITES OVERVIEW

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.

TRAINING SITES	% OF TRAINING
University of Kansas Hospital	60%-70%
Kansas City VA Hospital	30%-40%
Leavenworth VA Hospital	5%

CORE CURRICULUM

All trainees with the department of Internal Medicine are required to follow the ACGME program requirements for residency education. There are specific ACGME guidelines regarding each of the following educational experiences. Please visit ACGME's website for specific guidelines.

KUMC Internal Medicine Rotational Goals and Objectives can be found here:

- [KU BASED CURRICULA](#)
- [VA BASED CURRICULA](#)
- [LVAH CURRICULA](#)

Ambulatory Medicine
Emergency Medicine
Inpatient Medicine
Inpatient Medicine-Critical Care
Subspecialty Experience

3 + 1 BLOCK SCHEDULES

1. Block scheduling helps to separate inpatient and outpatient duties and minimize conflicts between inpatient responsibilities and outpatient clinical responsibilities. Residents will spend 3 weeks in a consult or inpatient setting including general medicine, subspecialty medicine and critical care exposure. They will then spend 1 week in a primarily ambulatory setting with increased didactic time.
2. Allows for longitudinal clinical experiences in sub-specialty training sites.
3. Increases exposure to a variety of ambulatory experiences.
4. Allows for a longitudinal board prep experience.
5. Allows for a weekend free of clinical duties at the end of most +1 weeks.

Sample scheduling showing 3 + 1 pattern over the course of the 4 firms.

Firm	week 1	week 2	week 3	week 4	week 5	week 6	week 7	week 8	week 9
Red	Rotation			+1	Rotation			+1	
Orange	+1	Rotation			+1	Rotation			+1
Yellow	Rotation	+1	Rotation			+1			
Green	Rotation		+1	Rotation			+1	Rotation	

Sample scheduling of Ambulatory +1 week.

+1 week	Monday	Tuesday	Wednesday	Thursday	Friday
AM	CC	CC	SC	CC	SC
PM	Board Study	SC	CC	Admin	Friday School
Weekly	Board Review Questions, IHI Modules, ambulatory podcast curriculum and chalk talks				

CC= Continuity Clinic

SC = Subspecialty Clinic

IHI = Institute for Healthcare Improvement

TYPICAL SCHEDULE AND ROTATIONS

	Categorical PGY-1	Categorical PGY-2/3	PreliminaryPGY-1
Wards	18-24 Weeks	13-16 Weeks	18-24 Weeks
Critical Care (MICU/CCU)	6-8 Weeks	6-8 Weeks	3-8 Weeks
Night Float	4-6 Weeks	2-4 Weeks	4-6 Weeks
Consults/Electives	3-6 Weeks	9-12 Weeks	16-18 Weeks
Clinic (+1 Week)	13 Weeks	13 Weeks	
Vacation	3 Weeks	3 Weeks	3 Weeks

First Year Residents (PGY 1: Categorical and Preliminary)

- 0-1 overnight shift weekend calls per inpatient block on general medicine and subspecialty wards at KU Med and KCVA only.
- No inpatient call while on non-inpatient blocks
- Preliminary year interns can spend time in destination programs per ACGME recommendations and these will primarily be during the +1 weeks.

Second- and Third-Year Residents (PGY 2 and PGY 3)

- 1-3 blocks of elective time (three total for all of training): International rotations, Research, Specialty/Clinical rotations of resident's choice (must meet requirements of program)
- 1-2 overnight 12-hour weekend call shifts per non-inpatient rotation

All Categorical Residents will complete an experience in:

- Clinical experiences in each of the internal medicine subspecialties
- Geriatrics
- Hospice and palliative medicine
- Addition medicine
- Emergency medicine
- Neurology

DEPARTMENT RULES AND 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.

Policy for Supervision of Residents and Progressive Responsibility for Patient Care (see also Appendix A, GME Supervision template)

INPATIENT PRACTICE

KUMC, KCVA Hospital, and Leavenworth VA Hospital:

All patients are assigned to a responsible faculty physician, who supervises all resident care and personally sees the patients 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. 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. It is necessary to page or call the on-call IM Chief to ensure immediate response.

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

PGY-1: It is the intern's responsibility to know all the relevant clinical data for his/her patients. 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 all his/her respective patients before rounds and present them in a succinct, thorough manner. It is also the intern's responsibility to communicate updates to the family. In partnership with the team, it is the intern's role to write the daily progress notes and discharge summaries.

PGY-2/3: The senior resident is responsible for all patients on the team and responsible for all aspects of supervision as it pertains to interns. Ideally, he/she should strive to see all the newly admitted patients, the acutely ill patients, and the planned discharges before rounds. When an intern is absent from rounds, it is the senior resident's responsibility to evaluate the intern's patients before rounds, present the patients during rounds, and write the daily progress notes. Additionally, it is the expectation that the senior resident will lead the daily huddle with nursing, PT/OT, social work, and case management to discuss patient disposition and coordination of care. Effective communication hinges on the senior resident and it is his/her responsibility to communicate directly with the attending physician, consulting physicians, nursing staff, and additional support staff.

Except for KU MICU and cardiovascular medicine teams, the senior resident is responsible for creating the rotational schedule for the team and submitting to the IM Chiefs for approval. The IM Chiefs will assign short call MOD shifts as well as Sunday long call shifts. The senior resident will assign the rest of the short call shifts and days off. In general, interns should be assigned to an average of eight and no more than nine short call shifts per three-week rotation (not including long call), and all residents should be assigned one day off per week. Any changes to Chief-assigned shifts must be approved by the IM Chiefs and requested through QGenda. The IM Chiefs will create rotational schedules for KU MICU and cardiovascular medicine teams.

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 and to ask if these expectations are not clear.

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

HANDOFFS

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 evidence-based handoff communication tool. All residents are introduced to the I-PASS model of change-of-duty handoffs during orientation. During the session, the IM Chiefs and faculty will assess each resident's ability to perform a safe and effective patient handoff. Smart phrases have been created in the electronic medical record to help facilitate use of this model. Morning and evening handoffs will be held in a standardized location at a standardized time at each facility.

EVENING/NIGHT COVERAGE FOR INPATIENT SERVICES

Inpatient general medicine services at KU and all inpatient services at the KCVA are responsible for taking calls on and admitting patients to their own service until 7pm. Inpatient teams can check out to the short call resident at 5pm on weekdays and noon on weekends as long as work is complete. The team's short call resident will remain in-house until 7pm to take calls on and to admit patients to his/her team. At KU, interns check out general medicine (including Med Oncology) short call admissions directly to a direct care attending. Hematology short call admissions must be supervised by a senior resident, typically the MOD, who will check the patient out to the hematology fellow. At the KCVA on weekdays, a separate swing senior is present from 4pm to 11pm to assist with admissions and consults. Admissions performed by short call interns can be supervised by the swing resident or a MOD. All admissions completed by interns that are not seen by an attending must be seen by a senior resident and include a documented senior resident attestation.

Interns and senior residents participate in a night float coverage system for both KU and the KCVA. The night float teams at KU and the KCVA are made up of a senior resident and two interns. Residents work six consecutive nights (Monday – Saturday night) and shifts begin at 7pm and end at 8am. The intern night residents' shifts may end after they have handed off all their patient's back to the day team, and after their work is completed. The night float team is responsible for cross covering academic teams, admitting patients, and completing any STAT general medicine consults. In general, the senior resident is responsible for completing/delegating admission responsibilities and providing support and supervision for the interns, and interns are responsible for cross coverage and assisting with admissions as delegated by the senior resident. Admissions should not exceed the defined ACGME limits. At KU, general medicine admissions before midnight performed by either the intern or senior resident can be checked out directly to a direct care hospitalist. Any general medicine patients admitted after midnight will be checked out by the senior resident to the on call academic hospitalist; senior residents supervise general medicine admissions completed by interns after midnight and document a senior attestation in the chart. Patients admitted in this way by intern residents count to the senior resident's total admission count. The senior resident must either preform or supervise all hematology admissions and the senior resident performs checkout to the fellow on call. At the KCVA, the senior resident is expected to checkout all general medicine patients to the VA hospitalist on call either by phone in the evening or the next morning. VA CV admissions should be checked out to the KU CCU fellow on call and VA MICU admissions should be checked out to either tele-ICU or the on-call MICU faculty as per MICU admission guidelines and faculty discretion. All intern admissions at the KCVA in the evening and overnight must be supervised by the senior resident and the senior resident must document an attestation.

To cover Sunday night shifts, inpatient interns may be scheduled to work a Sunday night shift that begins at 7pm. Interns will cross cover inpatient teams and assist with admission overnight. The following morning, interns will be expected to round on their patients and complete daily progress notes prior to leaving the hospital. It is the expectation that interns leave before noon after a Sunday night call. Sunday night MOD shifts are usually covered by senior residents on consults or electives.

Interns will primarily provide cross coverage overnight. Interns are expected to respond to calls in a timely manner and to assess patients as necessary. These calls have varying degrees of urgency and all requests to see patients should be taken seriously. Interns should 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.

For KU MICU and cardiovascular medicine services, weekday shifts are from 6am to 6pm for all resident team members. On weekends, residents may check out to the short call resident at 2pm if work is complete. Short calls are assigned only on weekends and holidays and scheduled by the IM Chiefs. The KU MICU and cardiovascular medicine services also participate in night medicine coverage. The MICU night medicine team consists of one senior resident and one intern, and the cardiovascular medicine services are covered by one senior resident. Night medicine teams are scheduled Monday – Saturday night from 6pm to 6am. Sunday nights are covered by a resident from one of the day MICU or cardiovascular medicine teams and are scheduled by the IM Chiefs. Night teams are responsible for all admissions (up to the defined ACGME admission limits) as well as cross coverage. Handoffs will occur at 6am and 6pm at specifically designated locations.

At the Leavenworth VA hospital, one resident from the inpatient team will be responsible for short call from 4pm until 6pm on Monday – Friday, at which time they will check-out to the in-house staff. On weekends, the entire resident team may checkout to the staff at noon if work is complete. Residents are not responsible for overnight calls on their patients while rotating at the Leavenworth VA.

CONSULT SERVICES KUMC, KCVA HOSPITAL

Consult 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 faculty point of contact for resident physicians.

Information about specific Consult Services can be found on the Blackboard site (bb.kumc.edu), under Internal Medicine Medical Education > Content > Forms, Downloads, and Documents > Rotation Information and Core Reading.

AMBULATORY CARE:

Continuity Clinic Expectations and Lines of Responsibility

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

The Resident 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:

- PGY-1 residents start with up to 4 patients per half-day clinic, end with up to 5 patients scheduled per half-day clinic

- PGY-2 residents will have up to 6 patients scheduled per half-day clinic
- PGY-3 residents will have up to 7 patients scheduled per half-day clinic
- Return patients are scheduled for 30 minutes, new patients are for 60 minutes

The clinic attending will review each patient with the resident, providing assistance with patient management decisions, and are required to see all PGY-1 resident patients through their sixth month of training. Often, an attending physician will choose to continue seeing the resident's patients if it is felt that the patient is complicated or acutely ill.

All office visit notes and documentation must be completed within 24 hours of the office visit, ideally on the same day of the office encounter. Prior to rotating off of the +1 week, residents 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. Exceptions are KU MICU, KU CCU, Night Float, and vacation as communicated with the anchor nurse and faculty preceptor. 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.

+1 Week Structure (half-day sessions):

- 4 sessions of continuity clinic
- 3 sessions of ambulatory subspecialty clinics
 - Allergy/immunology, CV, Cath Procedure, Dermatology, Endocrinology, medical ophthalmology, Geriatrics, GI, office gynecology, Hematology, Infectious Disease, JayDoc, Lipid Clinic, Oncology, Office Orthopedics, Pain Management, Palliative Care, PM&R, Pulmonary, Renal, Renal Transplant, Rheum, sleep medicine, Weight management
- 1 session of quality improvement, required for PGY-2, optional for others
- 1 session of dedicated panel management
- 1 session of self-study and board review
- 2 sessions for scheduled didactics (Friday School and ambulatory "Chalk-Talks")
- Residents may be eligible for 1 session per +1 week of longitudinal research/scholarly time as noted on the Electives website

Since changes to clinic schedules impact patient care, any requests for change to continuity care clinics must be made at least 60 days in advance, except in emergent situations. The logistics for requesting a change should always begin with emailing the IMChiefs to ensure patient coverage and resident compliance with ACGME guidelines for continuity clinics.

- KU cancellations will be communicated to IM Chiefs, bobbie fink, IM Scheduling, and faculty preceptor
- VA cancellations will be communicated to IM Chiefs, faculty preceptor, and Dr Mark Pence
- Westwood cancellations will be communicated to IM Chiefs and faculty preceptor
- For emergent/short notice cancellations, page/call the IM Chief on call
- Makeup Clinics:
 - If a resident is projected to be under-target for the targeted 130 clinics over three years, they will be scheduled for additional makeup clinics

EDUCATIONAL PATHWAYS

Our pathway opportunities allow for resident physicians to engage in an area of interest with focus and mentorship.

As a leadership team, we will highlight your engagement in a selected pathway at the time of graduation presuming the following minimum requirements are met:

1. Participation in opportunities: As deemed adequate by the pathway directors.
2. Dissemination of scholarship: This can be on a local, regional, or national level.

For active pathways, please visit our website.

[HTTPS://WWW.KUMC.EDU/SCHOOL-OF-MEDICINE/ACADEMICS/DEPARTMENTS/INTERNAL-MEDICINE/ACADEMICS/INTERNAL-MEDICINE-RESIDENCY-PROGRAM/OUR-PROGRAM/CUSTOMIZING-YOUR-EDUCATIONAL-EXPERIENCE/EDUCATIONAL-PATHWAYS.HTML](https://www.kumc.edu/school-of-medicine/academics/departments/internal-medicine/academics/internal-medicine-residency-program/our-program/customizing-your-educational-experience/educational-pathways.html)

ELECTIVE ROTATIONS

Each resident may be granted up to 3 elective experiences during residency training. Each elective experience may be up to 3 weeks in duration. If a particular interest is not represented by the elective offerings, residents have the option to self-design and propose an elective block. Please visit our website for more information about current elective opportunities.

[HTTPS://WWW.KUMC.EDU/SCHOOL-OF-MEDICINE/ACADEMICS/DEPARTMENTS/INTERNAL-MEDICINE/ACADEMICS/INTERNAL-MEDICINE-RESIDENCY-PROGRAM/OUR-PROGRAM/CUSTOMIZING-YOUR-EDUCATIONAL-EXPERIENCE/ELECTIVE-ROTATIONS.HTML](https://www.kumc.edu/school-of-medicine/academics/departments/internal-medicine/academics/internal-medicine-residency-program/our-program/customizing-your-educational-experience/elective-rotations.html)

GLOBAL HEALTH OPPORTUNITIES

An international educational experience can be a transformational learning experience during medical training. The KUMC Office of International Programs is committed to fostering and assisting with global outreach educational experiences of our Internal Medicine residents. The goal of the Office of International Programs is to support and ensure the safety and success of all international travel experiences. Because of the complexities of international travel and the need to be aware of Department of State and CDC Travel Warnings and other pertinent safety information, it is required that all resident international educational experiences be registered with and approved by the Office of International Programs. Owing to the desire to give logistical and safety support for all members of the KUMC community, it is also mandated that any faculty, resident, or staff member participating in an international professional experience as a representative of KUMC, register with the Office of International Programs in advance of travel. Information about programs, contacts and requirements are available at the Office of International Programs website

[HTTPS://WWW.KUMC.EDU/ACADEMIC-AND-STUDENT-AFFAIRS/DEPARTMENTS/OFFICE-OF-INTERNATIONAL-PROGRAMS/OUTBOUND-PROGRAMS/RESIDENT-TRAVEL-INFORMATION.HTML](https://www.kumc.edu/academic-and-student-affairs/departments/office-of-international-programs/outbound-programs/resident-travel-information.html)

To facilitate a global health opportunity, it is critical that all advanced planning timelines are met. Please visit our website for additional details regarding a global health opportunity.

[HTTPS://WWW.KUMC.EDU/SCHOOL-OF-MEDICINE/ACADEMICS/DEPARTMENTS/INTERNAL-MEDICINE/ACADEMICS/INTERNAL-MEDICINE-RESIDENCY-PROGRAM/OUR-PROGRAM/SCHEDULES-AND-CURRICULUM/TEACHING-CONFERENCES.HTML](https://www.kumc.edu/school-of-medicine/academics/departments/internal-medicine/academics/internal-medicine-residency-program/our-program/schedules-and-curriculum/teaching-conferences.html)

SIMULATION TRAINING

Our internal medicine residents are fortunate to have access to a variety of simulation opportunities throughout their residency training. This experiential learning enables our residents to apply their knowledge to a simulated, concrete experience, reflect on the encounter and then refine their future performance. As so elegantly stated by our team in the Zamierowski Institute for Experiential Learning, “by taking new knowledge and skills ‘for a test drive’ through experiential learning, our residents can integrate complex concepts, adapt medical knowledge to nuanced cases, learn from mistakes, and generate new ideas for improving patient care.”

The following is a snapshot of our current simulation opportunities:

Simulation	More details	PGY	Faculty Lead
Airway/Ventilator		ALL LEVELS	Thomas
Code Blue	Session 1	ALL LEVELS	Thomas
	Session 2	ALL LEVELS	Thomas
CVC	Study Hall	PGY 1, 2 opt out, 3+ opt in	Pandya
	Warm Up	PGY 1, 2 opt out, 3+ opt in	
	Training	PGY 1, 2 opt out, 3+ opt in	
	Wrap Up	PGY 1, 2 opt out, 3+ opt in	

Hypotension		PGY 1	Brubacher
Bradycardia		ALL LEVELS	Thomas
Tachyarrhythmia		ALL LEVELS	Thomas
End of Life		PGY 1	Kalender-Rich
Ultrasound/Para/Thora		ALL LEVELS	Pandya

For more information regarding simulation training please visit our website.

[HTTPS://WWW.KUMC.EDU/SCHOOL-OF-MEDICINE/ACADEMICS/DEPARTMENTS/INTERNAL-MEDICINE/ACADEMICS/INTERNAL-MEDICINE-RESIDENCY-PROGRAM/OUR-PROGRAM/CUSTOMIZING-YOUR-EDUCATIONAL-EXPERIENCE/SIMULATION-TRAINING.HTML](https://www.kumc.edu/school-of-medicine/academics/departments/internal-medicine/academics/internal-medicine-residency-program/our-program/customizing-your-educational-experience/simulation-training.html)

PROCEDURES AND EPA'S

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 the 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):

For a resident to perform a procedure without direct supervision, he/she must have completed the following with documentation in MedHub including promotion to indirect supervision by the program director:

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

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

DIDACTICS AND CONFERENCES

While much of residency education is acquired in the clinical environment, we strive to provide a well-rounded curriculum to better prepare residents for both the clinical environment and in preparation for boards. Our goal is to provide a core curriculum with an active learning environment, while efficiently utilizing the time of both our residents and faculty. We have daily conferences over the noon hour, as well as longer educational sessions during the +1 week when residents have fewer patient care responsibilities outside of clinic. The topics of the curriculum are developed from review of the ABIM certifying exam blueprint, as well as specific learning objectives tested on the Internal Medicine In-Training Examination.

Daily conference topics include:

- Case Conferences
- Lectures
- ACP Board Preparation Curriculum
- Journal Clubs
- Clinicopathologic Conferences
- Ethics Conferences
- Patient Safety Conferences
- GME Conferences
- Housestaff Meetings
- Chief Resident Conferences

+1 educational opportunities include:

- Simulations
- Recommendations for podcasts to listen to
- Half day workshops and interactive sessions (Friday School and ambulatory “Chalk Talks”)

Attendance at core conference is expected. Residents are expected to willingly take part in these conference opportunities. However, 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. Physical attendance is required at >50% of these mandatory Internal Medicine conferences. If rotational assignment does not allow physical attendance, conferences may be reviewed via recordings.

SCHOLARLY ACTIVITY

Our residents are very successful in disseminating scholarship while in training. While categorical residents are required to conduct two scholarly activities during their residency, most easily surpass this. The residency program offers up to 9 weeks of protected elective research time over three years of categorical training. Furthermore, residents are offered optional longitudinal protected research time during their ambulatory +1 week.

To facilitate resident research involvement, our program has appointed Research Liaisons from each of our subspecialty divisions. Liaisons connect residents with appropriate project mentors based on their interests, type of experience, and level of involvement they are seeking (i.e., research grants, manuscript, oral presentation, abstract, case report, QI project, etc.). We have appointed Liaisons in the following areas:

- Allergy/Immunology
- Cardiology
- Endocrinology
- Gastroenterology/Hepatology
- Pulmonology/Critical Care
- Hematology
- Oncology
- General Internal Medicine
- Nephrology
- Infectious Diseases
- Rheumatology
- Palliative Care
- Medical Education

The list of liaisons can be found at the below link:

[HTTPS://WWW.KUMC.EDU/SCHOOL-OF-MEDICINE/ACADEMICS/DEPARTMENTS/INTERNAL-MEDICINE/ACADEMICS/INTERNAL-MEDICINE-RESIDENCY-PROGRAM/OUR-PROGRAM/CUSTOMIZING-YOUR-EDUCATIONAL-EXPERIENCE/ACHIEVING-SCHOLARSHIP-IN-RESIDENCY.HTML](https://www.kumc.edu/school-of-medicine/academics/departments/internal-medicine/academics/internal-medicine-residency-program/our-program/customizing-your-educational-experience/achieving-scholarship-in-residency.html)

Our robust framework for involving residents in scholarship has provided numerous opportunities for local, regional, and national dissemination of their work at conferences and in medical journals. The department provides travel funds to assist with making this dissemination possible.

WORK HOURS

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.

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.

HONORS AND AWARDS

The Department is proud of its residents. Outstanding residents are recognized with several honors and awards.

Categorical Intern of the Year	Chosen by the faculty for outstanding performance
Preliminary/CBY Intern of the Year	Chosen by peers for outstanding teamwork
Milton McGreevy Award (PGY2)	Chosen by faculty for demonstrating excellence in Internal Medicine
Milton McGreevy Award (PGY3)	Chosen by faculty for demonstrating excellence in Internal Medicine
Mark Beck Award	Resident with the highest standards of caring and compassion as chosen by fellow Housestaff which celebrates the humanistic aspect of doctoring
Outstanding Resident Teaching Award	Chose by 3rd year medical students rotating through the Internal Medicine Department
Pingleton Service Award	Awarded to the resident who has shown exemplary service to the residency and to the medical community
Mahlon H. Delp Award for Clinical Excellence	Awarded to senior resident who has exhibited consistently outstanding clinical skills, knowledge, and compassion throughout their training

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 and parental leave.

[HTTP://WWW.KUMC.EDU/SCHOOL-OF-MEDICINE/GME/POLICIES-AND-PROCEDURES.HTML](http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html)

SCHOLARSHIP / EDUCATIONAL 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 \$634)

ACP Resident/Fellow Membership (value \$132)

PGY2 Categorical Residents:

ACP Resident/Fellow Membership (value \$132)

PGY3 Categorical Residents:

ACP Resident/Fellow Membership (value \$132)

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:

- Study materials for Step 3 or COMLEX 3.
- Test registration fee for Step 3 or COMLEX 3.
- Travel (air, lodging, meeting registration, local transportation) to a regional or national meeting to disseminate scholarship if attending as the presenting author.
- Costs associated with poster production and/or submission fees associated with dissemination of scholarship.
- Other educational books and/or resource with approval of the Program Director.
- Small medical equipment – such as additional white coats, on call jacket, stethoscope, ophthalmoscope, or otoscope (not to exceed \$200).

PGY1 Categorical Residents – Up to \$1000 to be utilized as follows:

- Study materials for Step 3 or COMLEX 3.
- Test registration fee for Step 3 or COMLEX 3.
- Travel (air, lodging, meeting registration, local transportation) to a regional or national meeting in order to present scholarship if attending as the presenting author.
- Costs associated with poster production and/or submission fees associated with dissemination of scholarship.
- Other educational books and/or resource with approval of the Program Director.
- Small medical equipment – such as additional white coats, on call jacket, stethoscope, ophthalmoscope, or otoscope (not to exceed \$200).

PGY2 Residents – Up to \$1250 to be utilized as follows:

- Travel (air, lodging, meeting registration, local transportation) to a regional or national meeting to present scholarship if attending as the presenting author.
- Costs associated with poster production and/or submission fees associated with dissemination of scholarship.

- Other educational books and/or resource with approval of the Program Director.
- Small medical equipment – such as additional white coats, on call jacket, stethoscope, ophthalmoscope, or otoscope (not to exceed \$200).
- Costs associated with renewal of BLS and/or ACLS.

PGY3 Residents – Up to \$1250 to be utilized as follows:

- Travel (air, lodging, meeting registration, local transportation) to a regional or national meeting in order to present scholarship if attending as the presenting author.
- Costs associated with poster production and/or submission fees associated with dissemination of scholarship.
- Other educational books and/or resource with approval of the Program Director.
- Small medical equipment – such as additional white coats, on call jacket, stethoscope, ophthalmoscope, or otoscope (not to exceed \$200).
- Costs associated with renewal of BLS and/or ACLS.
- Registration for the ABIM certifying examination.

PGY3 Residents – 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.

PROFESSIONAL

- Membership dues to the ACP (American College of Physicians) paid annually

AT WORK

- 24-hour secured parking garage paid for by the health system
- Two sets of scrubs and white coats provided
- UpToDate access throughout the hospital
- Meal allocations at KU: All residents will receive \$\$50 per pay period
- Meal allocations at VA: 24-hour access to food if on call (snacks, frozen meals, juices, etc.)
- 24-hour access to resident lounge with large screen TV, computers, DVD player and snacks

LEAVE – SICK, VACATION, PARENTAL, WELLNESS DAYS

The American Board of Internal Medicine allows up to five (5) weeks per year, as time away from the program. Time away from the program beyond this ABIM allocated leave will be required to be made up in order to be eligible for the ABIM certifying examination. The ABIM does not distinguish between vacation time or leave for illness, including pregnancy-related leave, and includes them as time away from the program.

SICK

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:

- Inform others on his/her team of the absence including supervising resident/fellow (if applicable) and attending physician.
- Contact the Chief Resident on-call.
- Submit a sick day request via email to IM Chiefs for record keeping.

Should a resident be required to quarantine as per KU Infection Protection and Control (IPAC), but remain well enough to work, accommodations for non-clinical elective work may be arranged with the Chief Residents and Program Director to minimize use of sick days.

RESILIENCY AND SUPPORT

Your wellbeing is a priority to us. Below is a link to the resources provided by the University of Kansas Health System that includes:

- Basic Care Resources
- Medical Support (including rapid appointment scheduling)
- PPE Guidelines
- Mental and Emotional Health resources
- Physical Wellbeing
- Resources for Parents and Care Providers
- Community Connection and Engagement
- Etc.

[HTTPS://WWW.KANSASHEALTHSYSTEM.COM/FOR-EMPLOYEES/COVID-19/RESILIENCY-AND-SUPPORT](https://www.kansashealthsystem.com/for-employees/covid-19/resiliency-and-support)

If you are concerned about another resident, please notify IM Chiefs or Program Leadership including Program Directors so that additional measures can be taken to provide support for the resident of concern.

VACATION

All House Staff are entitled to 15 days of vacation per year, not to exceed two weeks (14 days) in a row of absence. Vacations are typically scheduled Monday through Friday; the weekend off prior to the start of vacation is not guaranteed and will depend on the specific circumstances of any given rotation, the weekend after the given vacation days is guaranteed to not have clinical responsibilities. 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.

One vacation week per year may be split one way (for example 4 and 1 or 3 and 2 days) during consults and +1 weeks, pending approval by IM Chiefs. Vacation weeks that contain a holiday may not be split up. If residents split their vacation on +1 weeks, continuity clinic must not be interrupted due to the split. No more than two +1 weeks may be utilized for vacation per academic year. A maximum of 5 total days of vacation may be used on +1 weeks. Residents who take vacations over a holiday will not be credited an additional vacation day. Requests to split vacation weeks outside of schedule build must be placed with the IM Chiefs 60 days in advance.

Under certain circumstances, requests can be granted for a change in vacation dates. These must go through the IM Chiefs to be approved. As it relates to scheduled clinics, clinics may be cancelled by the chief residents if requests are made via email to IM Chiefs greater than 60 days prior to the expected absence. Vacation taken during the +1 week may require make-up clinics if the resident falls short of ACGME continuity clinic requirements. If vacation changes are requested less than 60 days in advance and they impact continuity clinics, the vacation change request must be cleared by the designated ambulatory clinic site director. In this circumstance, if approved by the ambulatory clinic site director and the IM Chiefs, it is expected that the resident physician will work with their ambulatory supervising faculty and ambulatory clinic site director to determine a satisfactory plan to reschedule patients.

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.

MEDICAL, PARENTAL AND CAREGIVER LEAVE

The University of Kansas Medical Center recognizes and support the importance of work-life balance, particularly as it relates to managing family and professional obligations. For all instances of medical, parental or caregiver leave, please visit the [GME Policy and Procedure Manual](#) for more information including necessary steps to initiate leave.

WELLNESS

Each resident, including preliminary year residents, 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 or during a consult block not included in the list below. Wellness days must be requested at least 14 days in advance. Requests are sent to, evaluated, and approved by the IM Chiefs 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.

These days are open to preliminary residents as well as categorical residents subject to the same requirements as above. Your primary program will be notified of the change to ensure that the wellness day does not interfere with any of your program's requirements.

Exempted Blocks

- Geriatrics
- Neurology
- Emergency Medicine
- Electives

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 is not utilized for this wellness consultation.

BEREAVEMENT

The Internal Medicine program adheres to GME policy regarding bereavement (“funeral”) leave for residents as seen in the KUMC GME Manual linked below.

[HTTPS://WWW.KUMC.EDU/SCHOOL-OF-MEDICINE/GME/INFORMATION-FOR-RESIDENTS-AND-FELLOWS/POLICIES-AND-PROCEDURES.HTML](https://www.kumc.edu/school-of-medicine/gme/information-for-residents-and-fellows/policies-and-procedures.html)

PROFESSIONAL DAYS

Professional days to cover professional activities such as interviews, conference attendance or presentations, and educational meetings may be granted to a resident pending leadership approval. The resident has the responsibility to find coverage for essential services such as inpatient medicine or ICU services. When coverage is found, the resident shall email IM Chiefs and CC the resident who agreed to provide coverage to request the schedule change.

PROCEDURE FOR END OF TRAINING LEAVE REQUESTS/EQUITABILITY OF SERVICE REQUIREMENTS:

1. If residents are exiting training to an employed position, they are expected to work through (and including) June 30th of the academic year.
2. If residents are exiting training to additional ACGME accredited training AND requiring a move from Kansas City (ex: fellowship)
 - a. Submit fellowship orientation schedule to IMChiefs
 - b. Once orientation schedule is reviewed, with program approval, residents may be granted up to 5 days of professional leave to accommodate moving and orientation requirements for upcoming fellowship
 - c. If the resident physician is requesting professional leave to facilitate transition to another ACGME accredited training program outside of Kansas City, the resident physician MUST ensure that they are on a rotational assignment that allows for utilization of professional days. It is the responsibility of the resident physician to make scheduling changes to accommodate this leave utilization.
3. Residents on their +1 week during the last week of their training:
 - a. If continuity counts are >130, residents will complete their 1st scheduled continuity clinic of the week, then may be excused from additional continuity clinic the

remainder of the week, if desired. IMChiefs will communicate with clinic scheduling prior to April 1 to minimize patient care scheduling disruptions.

- b. Even if continuity clinics are canceled, these residents are expected to work through (and including) June 30th of the academic year.
- c. These residents can anticipate being utilized for inpatient coverage / backup when needed.

APPENDICES

APPENDIX A: 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. VI.A.2.a).(1)
- This information must be available to residents, faculty members, other members of the health care team, and patients. VI.A.2.a).(1)(a)
 - 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. VI.A.2.a).(1)(b)
- The program must demonstrate that the appropriate level of supervision 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. VI.A.2.b).(1)

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 appropriate availability of the supervising faculty member, fellow or senior resident physician, and either on site or by means of telecommunication technology. 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. VI.A.2.b)
- The program must demonstrate that the appropriate level of supervision 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. VI.A.2.b).(1)
- The Review Committee may specify which activities require different levels of supervision. VI.A.2.b).(1)
- The program must define when physical presence of a supervising physician is required. (Core) VI.A.2.b).(2)

C. Levels of Supervision Defined

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

Direct Supervision:

- **Direct A:** The supervising physician is physically present with the resident during the key portions of the patient interaction or, VI.A.2.c).(1).(a) PGY-1 residents must initially be supervised directly only as described in VI.A.2.c).(1).(a) [The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]

- **Direct B:** The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. [The Review Committee must further specify if VI.A.2.c).(1).(b) is permitted] [The Review Committee will choose to require either VI.A.2.c).(1).(a), or both VI.A.2.c).(1).(a) and VI.A.2.c).(1).(b)] VI.A.2.c).(1).(b)

Indirect Supervision:

The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. VI.A.2.c).(2)

Oversight:

- The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. VI.A.2.c).(3)

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. VI.A.2.d)

Per Program Specific RRC Requirements	Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or RRC APPROVED LICENSED INDEPENDENT PRACTITIONER SUPERVISOR) who is responsible and accountable for the patients care, 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))
	Information regarding licensure for attending physicians is available via a publicly available database: 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.
	Residents and Faculty members must inform each patient of their respective roles in patient care, when providing direct patient care. VI.A.2.a). (1).(b.)
	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 initially be supervised directly only as described in VI.A.2.c).(1).(a) [The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly] VI.A.2.c).(1).(a).(i)
	PGY-1 residents are supervised, either directly or indirectly with direct supervision immediately available on site, by senior residents, fellows, or faculty members on all rotations, including night float, at all training sites. At all sites, during daytime inpatient, consult, and outpatient rotations, supervision is direct and occurs by an attending physician

as well as a senior resident and/or fellow in many circumstances. 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 immediately available by pager and is available to return to the facility 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.4.a.)

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 clinical work and education 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. Residents must not be assigned more than two months of night float during any year of training, or more than four months of night float over the three years of residency training. Residents must not be assigned more than one month of consecutive night float.

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. Unplanned procedure
9. Procedural complication
10. Unexpected patient death



Work Standard

Title: Red Event Definition		Date: 12/21/2016
Departments who must adopt: The University of Kansas Health System (TUKH)		Operators who must adopt: All TUKH employees

NOTE: THIS IS A CONTROLLED DOCUMENT THAT SUPPORTS A SPECIFIC PROCESS

RED EVENTS - DEATH AND SERIOUS INJURY AND/OR NEAR MISS

- | | |
|---|---|
| <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ Unexpected peri-natal death ○ Unexpected infant death ○ Unexpected maternal death or serious disability • Medication error with serious injury and/or death • Elopement 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) | <ul style="list-style-type: none"> • Procedural and perioperative events <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ 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 |
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Process Owner: Assistant Director of Quality / Magnet / Research Approved by: Quality Risk Committee Version: 1.0-12/21/16

Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core) (VI.E.3.e)

Trainees will contact the chief resident on call if fatigue, illness, family emergency, or parental leave will cause the trainee to be unable to perform patient care duties (VI.C.2-VI.C.2.b and VI.D.2. (Core)).

Fatigue - Program call rooms should be utilized for fatigued residents for rest and/or power napping.

Resident physicians are encouraged to utilize Uber or other similar transportation service to safely travel home and return to work in circumstances when they are fatigued. With

submission of receipts for such transportation to the program coordinator, residents will receive reimbursement for transportation costs incurred.

Illness or Family Emergency – in the event of an unexpected illness or emergency, the trainee is expected to contact the chief resident on call who will communicate with the team on the trainee's behalf to ensure proper hand-off of patient care. It is the responsibility of the trainee and chief resident to contact the program director and coordinator to document the incident according to the institutional policies regarding such absences.

Parental or Medical Leave – the trainee and program director will work with the chief residents to arrange coverage for a parental or medical leave to ensure continuity of patient care through the duration of leave.

PGY 1	
LEVEL of SUPERVISION	ACTIVITIES /PROCEDURES (as defined by RRC & Program)
DIRECT A	Arterial blood draw Arterial line Arthrocentesis Bone marrow aspiration Bone marrow biopsy Bronchoscopy Cardioversion Chest tube placement Intubation, elective Intubation, emergent Laryngeal mask airway Lumbar puncture Nasogastric tube placement Pap smear (until at least one performed) Paracentesis Thoracentesis Ultrasound for central line placement.
DIRECT B	N/A
INDIRECT	ACLS Electrocardiogram interpretation (preliminary interpretation) Peripheral IV Radiology interpretation (preliminary interpretation) Venous blood draw

All OTHER RESIDENTS	
LEVEL of SUPERVISION	ACTIVITIES /PROCEDURES (as defined by RRC & Program)
DIRECT A	Bone marrow aspiration Bone marrow biopsy Bronchoscopy Cardioversion Chest tube placement Intubation, elective

	Intubation, emergent Laryngeal mask airway
DIRECT B	N/A
INDIRECT	<p>ACLS Arterial blood draw Electrocardiogram interpretation Incision and drainage of an abscess Nasogastric tube placement Pap smear Peripheral IV Radiology interpretation Venous blood draw</p> <p>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:</p> <p>Arterial line placement Arthrocentesis Central venous line placement Lumbar puncture Paracentesis Thoracentesis Ultrasound for central line placement</p>
OVERSIGHT	N/A