Hennepin County Medical Center
Internal Medicine Residency Program

Resident Handbook: Policies and Guidelines

Welcome
On behalf of the institution and the Department of Internal Medicine, welcome to Hennepin County Medical Center. We are pleased you have chosen to train in our independent residency program with a long history of training internists in preparation for clinical, academic and community leadership positions.

This manual contains information about program policies and procedures, resident roles and responsibilities, the ACGME core competencies, and the national duty hour requirements. It is meant as an accompaniment to the institutional residency manual, also available here on the New Innovations Residency Management Suite (RMS).

Residents are responsible for knowing and adhering to the guidelines and policies included in this handbook. If any questions or concerns arise, residents are expected to contact the Program Director.

Mission Statement
The core mission of the Internal Medicine Residency at Hennepin County Medical Center is to provide outstanding training in the practice of medicine by offering our residents the opportunity to practice in an atmosphere of supervised autonomy and of scholarly inquiry. Our faculty is committed to training professionally responsible physicians focused on patient care, medical education, and scholarship.

Hennepin County Medical Center Internal Medicine Residency Manual

ACGME SIX GENERAL COMPETENCIES

GENERAL COMPETENCY DEFINITIONS AND PROGRAM POLICY

The residency program requires our residents to develop the competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, we define specific knowledge, skills, and attitudes required for promotion and provide educational experiences as needed in order for our residents to demonstrate the competencies.

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

Residents are expected to:

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families

2. Gather essential and accurate information about their patients

3. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment

4. Develop and carry out patient management plans

5. Counsel and educate patients and their families

6. Use information technology to support patient care decisions and patient education

7. Perform competently all medical and invasive procedures considered essential for the area of practice

8. Provide health care services aimed at preventing health problems or maintaining health

9. Work with health care professionals, including those from other disciplines, to provide patient-focused care

MEDICAL KNOWLEDGE: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
Residents are expected to:

1. Demonstrate an investigatory and analytic thinking approach to clinical situations

2. Know and apply the basic and clinically supportive sciences which are appropriate to their discipline

PRACTICE-BASED LEARNING AND IMPROVEMENT: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Residents are expected to:

1. Analyze practice experience & perform practice-based improvement activities using a systematic methodology

2. Locate, appraise, & assimilate evidence from scientific studies related to their patients' health problems

3. Obtain and use information about their population of patients and the larger population from which their patients are drawn

4. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness

5. Use information technology to manage information, access on-line medical information; and support their education

6. Facilitate the learning of students and other health care professionals

INTERPERSONAL AND COMMUNICATION SKILLS: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.
Residents are expected to:

1. Create and sustain a therapeutic and ethically sound relationship with patients

2. Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills

3. Work effectively with others as a member or leader of a health care team or other professional group

PROFESSIONALISM: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
Residents are expected to:

1. Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development

2. Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices

3. Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

SYSTEMS-BASED PRACTICE: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
Residents are expected to:

1. Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice

2. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources

3. Practice cost-effective health care and resource allocation that does not compromise quality of care

4. Advocate for quality patient care and assist patients in dealing with system complexities

5. Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

COMPETENCY-BASED EDUCATIONAL GOALS AND OBJECTIVES BY YEAR OF TRAINING

BY COMPLETION OF THE PGY1 YEAR, RESIDENTS SHOULD BE ABLE TO PERFORM THE FOLLOWING WITH

1. **Up to 5 new admissions**
2. **Up to 10 hospitalized patients**
3. **Up to 6 patients in a ½ day continuity clinic session:**

Patient Care

1. Acquire accurate and relevant history from patients
2. Seek and obtain appropriate data from secondary sources
3. Perform an accurate, targeted physical exam and track important changes over time
4. Synthesize all available data to define patients' central clinical problems
5. Make appropriate clinical decisions based on results of common diagnostic changes
6. Recognize urgent/emergent situations and when to seek additional guidance
7. Manage common clinical conditions with supervision, and stabilize emergent conditions

Medical Knowledge

1. Understand relevant pathophysiology and basic science for common medical conditions
2. Demonstrate sufficient knowledge to diagnose and treat common medical conditions
3. Understand indications for and basic interpretation of common diagnostic testing

Practice-Based Learning and Improvement

1. Appreciate the responsibility to assess and improve care collectively for a panel of patients
2. Identify learning needs as they emerge in patient care activities
3. Access appropriate medical information resources to answer clinical questions/support decisions
4. Effectively and efficiently search NLM database for original clinical research articles
5. With assistance, appraise study design, conduct and statistical analysis in clinical research papers
6. Determine if clinical evidence can be generalized to an individual patient
7. Respond productively to feedback from ALL members of the health care team

8. Actively participate in teaching conferences

Interpersonal and Communication Skills

1. Provide comprehensive, timely verbal and written communication to patients/families/advocates
2. Effectively use verbal/nonverbal skills to establish rapport with patients/families/advocates
3. Effectively use an interpreter to engage patients, including in patient education
4. Effectively communicate with other caregivers to maintain continuity in transitions of care
5. Deliver appropriate, succinct, hypothesis-driven oral presentations
6. Effectively communicate plan of care to all members of health care team
7. Request consultative services in an effective manner
8. Clearly communicate the role of the consultant to the patient, in support of primary care team
9. Provide accurate, complete, **timely** written clinical documentation congruent with medical standards

Professionalism

1. Document and report clinical information truthfully
2. Accept personal errors and honestly acknowledge them
3. Demonstrate empathy & compassion for all patients, with a commitment to relieve pain and suffering
4. Communicate constructive feedback to other members of the health care team
5. Respond promptly and appropriately to clinical responsibilities, including all calls and pages
6. Carry out timely interactions with colleagues, patients, and their designated caregivers
7. Recognize and manage obvious conflicts of interest
8. Ensure prompt completion of clinical, administrative and curricular tasks
9. Recognize disparities in health care that may impact care of the individual patient

Systems-Based Practice

1. Understand unique roles and services provided by local health care delivery systems
2. Appreciate roles of a variety of health care providers (eg. social workers, pharmacists, PHNs)
3. Work effectively as a member within the interprofessional team to ensure safe patient care
4. Recognize health system forces that increase the risk for error
5. Identify, reflect on and learn from critical incidents (eg, near misses, preventable errors)

6. Reflect awareness of common socioeconomic barriers that impact patient care
7. Understand how cost-benefit analysis is applied to patient care (eg, screening guidelines)
8. Identify costs for common diagnostic or therapeutic tests and minimize unnecessary care

IN ADDITION TO OBJECTIVES FOR THE PGY1 YEAR, BY COMPLETION OF THE PGY2 YEAR, RESIDENTS SHOULD BE ABLE TO PERFORM THE FOLLOWING WITH

1. **Up to 10 new admissions (via supervision of 2 PGY1s)**
2. **Up to 20 hospitalized patients (via supervision of 2 PGY1s)**
3. **Up to 7 patients in a ½ day continuity clinic session:**

Patient Care

1. Obtain relevant historical subtleties that inform and prioritize differential diagnoses and diagnostic plans, including those that might not be volunteered by patients
2. Teach how to elicit important physical findings to junior members of health care team
3. Appropriately modify differential diagnosis and care plan based on clinical course
4. Make appropriate clinical decisions based on results of more advanced diagnostic tests
5. Provide specific, responsive consultations to other services

Medical Knowledge

1. Demonstrate knowledge to diagnose and manage common ambulatory and inpatient conditions, including intensive care
2. Demonstrate sufficient knowledge to provide appropriate preventive care
3. Understand indications for and have basic skills in interpreting more advanced diagnostic tests
4. Understand concepts of prior probability and test performance characteristics

Practice-Based Learning and Improvement

1. Perform audit of panel of patients using standardized, disease-specific evidence-based criteria
2. Reflect on audit compared with local/national benchmarks and explore possibilities for discrepancies
3. Classify and articulate clinical questions and develop system to track, pursue and reflect on them
4. Efficiently and effectively search and apply evidence-based summary medical information resources
5. With assistance, appraise clinical guidelines
6. Customize clinical evidence for individual patients
7. Calibrate self-assessment with feedback and other external data, reflect in plans for improvement
8. Integrate teaching, feedback and evaluation with supervision of interns' and students' patient care

Interpersonal and Communication Skills

1. Engage patients/advocates in shared decision making
2. Use patient-centered education strategies
3. Role model and teach effective communication with other caregivers during transitions of care
4. Ensure succinct, relevant, and patient-specific written communication

Professionalism

1. Provide support to dying patients and their families
2. Provide team leadership that respects patient dignity and autonomy
3. Recognize, respond to, & report impairments in colleagues or substandard care via review process
4. Recognize & take responsibility for times where public health supersedes individual patient needs
5. Recognize need to assist colleagues in provision of duties

Systems-Based Practice

1. Manage and coordinate care and care transitions across multiple delivery systems
2. Dialogue with team members to identify risk for and prevention of medical error
3. Understand mechanisms for analysis and correction of systems errors
4. Identify the role of various health care stakeholders, including providers, suppliers, purchasers, etc
5. Understand coding and reimbursement principles
6. Demonstrate the incorporation of cost-awareness principles into standard clinical judgments

IN ADDITION TO OBJECTIVES FOR THE PGY1 AND PGY2 YEARS, BY COMPLETION OF THE PGY3 YEAR, RESIDENTS SHOULD BE ABLE TO:

Patient Care

1. Role model gathering subtle and reliable information from the patient for junior members of the team
2. Routinely identify subtle or unusual physical findings that may influence clinical decision making
3. Recognize disease presentations that deviate from common patterns and require complex decisions
4. Manage patients with a broad spectrum of clinical disorders seen in the practice of general medicine
5. Customize care in the context of the individual patients preferences and overall health
6. Provide internal medicine consultation for patients with more complex clinical problems requiring complex risk assessment

Medical Knowledge

1. Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions
2. Understand relevant pathophysiology and basic science for uncommon/complex medical conditions
3. Demonstrate sufficient understanding of sociobehavioral sciences (eg. ethics, health economics)

Practice-Based Learning and Improvement

1. Identify areas in own practice/system that can be changed to improve care
2. Engage in quality improvement intervention
3. Appraise quality of medical information resources; among them select one appropriate to question
4. Independently assess clinical guidelines for bias and cost-benefit considerations
5. Communicate risks, benefits and alternatives to patients
6. Integrate clinical evidence, clinical context and patient preferences into clinical decision making
7. Reflect, when surprised, apply new insights into future care, and reflect back on process
8. Take a leadership role in education of all members of the health care team

Interpersonal and Communication Skills

1. Engage patients in shared decision making for difficult, ambiguous or controversial scenarios
2. Counsel patients about risks/benefits of tests/procedures, highlighting cost awareness/resource allocation.

3. Role model effective communication skills in challenging situations
4. Engage in collaborative communication with all members of the health care team
5. Communicate consultative recommendations to referring team in an effective manner

Professionalism

1. Serve as a professional role model for more junior colleagues
2. Effectively advocate for individual patient needs
3. Recognize and manage conflict when patient values differ from their own
4. Embrace physicians' role in assisting the public/policy makers in understanding and addressing causes of disparity in disease and suffering
5. Advocates for appropriate allocation of limited health care resources

Systems-Based Practice

1. Negotiate patient-centered care among multiple care providers
2. Demonstrate how to manage the team by using skills and coordinating activities of interprofessional team members
3. Demonstrate ability to understand and engage in a system-level quality improvement intervention
4. Partner with other health care professionals to identify and propose improvement opportunities within the system
5. Demonstrate the incorporation of cost-awareness principles into complex clinical scenarios

*****PLEASE REFER TO THE INSTITUTIONAL POLICY TO REVIEW REQUIREMENTS FOR SUCCESSFUL COMPLETION OF THE USMLE STEP III EXAMINATION*****

CLINICAL RESPONSIBILITIES BY YEAR OF TRAINING

<table>
<tr><th>PGY1s</th><th>PGY2s</th><th>PGY3s</th></tr>
<tr><td>Inpatient Wards:
1. Admit up to 5 patients/night
• H&Ps and formulate plan
• Admission orders
• Provide initial evaluation for cross coverage on call
2. Care for up to 10 inpatients
• Examine patients at least twice daily
• Daily progress notes**
• Write all orders
• Knowledge of care plan and rationale for patients
• Provide written & verbal sign-outs on PGY2/3s day off
3. Familiarize themselves with patients cared for by medical students and PGY2/3
• Answer questions about care plan
• Act as primary provider on medical student day off
• Sign out medical student patients on senior day off</td><td colspan="2">Inpatient Wards:
1. Supervise admissions of up to 10 patients/night
• Review intern H&P, review of key elements
• Write a brief clarifying or supporting admit note after reviewing intern admission
• Review admission orders
• Provide back-up support for interns on cross cover
2. Supervise care for up to 20 inpatients
• Interview/examine patients at least daily
• Review notes & sign orders on medical student patients
• Dictate discharge summaries on all patients
• Knowledge of care plan and rationale for patients
• Review & cosign notes/sign all orders for medical student patients
• Provide verbal and written sign-outs to on-call interns
• Notify primary care physician of patient admission, major change in patient status, and plan for patient discharge
• Communicate at least daily with supervising staff physician, more frequently as necessary due to changes in patient status
PGY3 responsibilities are as the PGY2s, with the addition of being responsible for in hospital consultation for PGY2s with questions or concerns</td></tr>
<tr><td>Consultative Services:
Provide initial evaluation for all patients with weekday consultation request for covered service on day of request unless otherwise specified by primary team.
Provide weekend coverage for consults as agreed upon by primary team, provided they have, on average, at least one full day off in 7, including at home pager call.</td><td colspan="2">Consultative Services:
Responsibilities as PGY1s, with the exception that on all PGY2 consult rotations, some with weekend responsibilities.

PGY3 responsibilities as PGY2s, with the exception that residents are responsible to provide weekend coverage, provided they have, on average, at least one full day off in 7, including at home pager call</td></tr>
<tr><td>Ambulatory:
1. See ≤6 patients in a ½ day clinic
2. Create a primary care patient list on EHR, to ensure timely lab review and admission notification
2. Provide appropriate follow-up care for primary care pts
3. Complete visit notes on day of service</td><td colspan="2">Ambulatory:
Responsibilities as the PGY1s, with the exception of being responsible for the care of up to 9 patients per ½ day session</td></tr>
<tr><td colspan="3">**The progress notes should be entered in a problem oriented fashion & should include a pertinent evaluation of the patient's general condition, important events in the course of the patient's illness, & changes in physical findings. They should include the results of specific diagnostic maneuvers or any changes in treatment schedule. This policy was instituted to ensure that the residents' appraisal, thought processes and plan for the patient are documented in the chart, thereby communicating to staff and consultants the rationale for the patient's care plan.</td></tr>
</table>

DUTY HOURS

DUTY HOURS POLICY

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

1. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and **inclusive of internal and external moonlighting**.

2. Duty periods of PGY1 residents must not exceed 16 hours duration.

3. PGY1 residents are not allowed to moonlight.

4. Residents are provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. If you are not getting the days off, please contact one of the Chief Residents and/or the Program Director.

5. Adequate time for rest and personal activities is provided. This consists of a minimum 10-hour time period or a mandatory 8-hour time period (with justification), provided between all daily duty periods, and after in-house call.

On-Call Activities
The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when residents are required to be immediately available at HCMC.

1. In-house call will occur no more frequently than every third night.

2. Continuous on-site duty, including in-house call, will not exceed 24 consecutive hours. Residents may remain on duty for up to **2** additional hours to participate in didactic activities, transfer care of patients and maintain continuity of medical care. **Interns will not work beyond 16 consecutive hours.**

3. No new patients may be accepted after 24 continuous hours on duty. A new patient is defined as any patient for whom the resident has not previously provided care.

4. At-home call (pager call) is defined as call taken from outside HCMC.

5. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call are provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

6. When residents are called into HCMC from home, the hours residents spend in-house are counted toward the 80-hour limit.

Medical Students:
Please follow Dr. Samuel Ives's policy on days off for students.

DUTY HOURS DOCUMENTATION

The program requires residents to document their duty hours on a weekly basis and periodically reviews these duty hour logs to ensure compliance with ACGME requirements. These logs are also used to identify rotations consistently not in compliance, to target areas that need structural modification.
We use Residency Management Suite (RMS) to track duty hours and clinical responsibilities.
PLEASE TRUTHFULLY DOCUMENT IN RMS TO ACCURATELY REFLECT YOUR HOURS WORKED.

MOONLIGHTING POLICY

- **NO PGY1s ARE PERMITTED TO MOONLIGHT**

- All residents eligible to moonlight must sign a moonlighting permission form from the Medicine Education Office at the beginning of their G2 year, and must meet requirements outlined within.

- We recommend against **any** moonlighting activity while on ward call rotations.

- Moonlighting activity may occur on non-ward, non-call rotations as ***long as it does not interfere with educational and patient care performance in the residency.***

- Instances in which moonlighting activity is suspected to adversely impact resident performance will be investigated by the Chief Residents and the Program Director. If necessary, appropriate remediation will be initiated.

- Residents are not allowed to moonlight more than one consecutive night.

- Residents cannot moonlight when they are on back-up call. When on the Jeopardy Service, the Chief Residents will need to approve any moonlighting shifts.

- Residents must have a Minnesota medical license to moonlight off campus.

- J1 visa holders are **not** able to moonlight. This is consistent with ECFMG requirements.

- **Residents MUST NOT exceed the 80 hours/week rule or the 24 hours continuous duty plus 6 additional hours for follow-up with internal or external moonlighting. The program tracks these hours.**

Moonlighting activity may be prohibited by the Program Director and/or Clinical Competency Committee for residents whose performance is deemed marginal.

MEDICAL LICENSURE

A Minnesota medical license may be obtained after successfully completion of the G1 residency year.

Residents must complete USMLE Step 3 by January of their PGY2 year. They are encouraged to apply for licensure as soon as possible after completion of this exam, as this reduces complications when applying for jobs at the end of residency. Additionally, once licensure is obtained, DEA registration can be completed through HCMC on a "fee-exempt" status, saving the resident almost $400.

Completion of the USMLE Step 3 exam early during training has the additional benefit of allowing residents to focus on preparation for the ABIM certification exam during their PGY2 and PGY3 years, rather than needing to focus on preparation for the USMLE Step 3 exam, not all of which is applicable for the certification examination.

International medical graduates (IMGs) must have 2 years of US medical training to apply for a MN medical license. **IMGs training on a J-1 visa MAY NOT moonlight inside or outside of the training program.**

WARD COVERAGE

General Inpatient Medicine:
The General Inpatient Medicine ward services consist of 6 geographical unit-based inpatient resident teams: Med1 (Nokomis), Med2 (Calhoun), Med3 (Isles), CaRe1 (Harriet), CaRe2 (Hiawatha), CMIC (Cedar). Each team will be responsible for day to day care of all patients on their team, in addition, will be responsible for admissions to their Superunit every third day from 7a-7p. Superunits are divided between the Red 5 Inpatient Medicine units (Med1, Med2, Med3) and the CaRe/CMIC units (CaRe1, CaRe2, CMIC)

Night float will consist of 3 senior residents and will admit patients from 7pm-7am. There will also be a Swinger/Admitter resident to help the call teams from 4:30pm-9pm.

Please ask the Chiefs if there are any questions or concerns.

Yellow Medicine:
There are four MICU resident teams; Yellow A, Yellow B, Yellow C, and Yellow D. In addition, there is a nightfloat system on Yellow Medicine that has been modified several times over the years to ensure duty hour compliance and to optimize quality of patient care and residents' experience. The Yellow nightfloat arrives at **8pm** for a verbal signout session with the Yellow Senior resident. They admit all MICU patients overnight and stay through team rounds the next morning, typically between 9-10am. This provides the opportunity for some overlap and continuity in the staff morning rounds. Interns will rotate for night coverage one week out of their four weeks in the MICU. Staff are expected to begin rounds at 8am and first see new and most unstable patients with the nightfloat resident present.

Red Medicine:
There are two Red (Renal) Medicine teams; Red A and Red B. In addition, there is a Red nightfloat system. The nightfloat resident covers admissions from **8pm** until 7:30am. The nightfloat resident stays through post call rounds to present any overnight admissions. They must leave by **10 am** at the latest. In the first half of the academic year, this responsibility will fall to PGY2s. PGY1s **who have completed a month of red medicine** may do some nightfloat shifts in the second half of the PGY1 year.

ELECTIVE AND SELECTIVE PROGRAM

ELECTIVE POLICY

The HCMC categorical internal medicine residency is committed to providing protected time for residents to pursue professional interests in an in-depth fashion. The elective months provide an opportunity to explore **clinical and clinical research** opportunities not otherwise offered during the structured curriculum, or to pursue a clinically based research project.
In order to maintain consistency of educational experiences and to document resident activities, the Medicine Education Office requires an elective request form to be completed **at least six weeks** prior to the elective period. The Program Director must approve all electives.
Due to criteria for Medicare reimbursement, the elective needs to include clinical care and if research based, the research **MUST BE** clinical and clearly linked to the patient care experiences of the resident. Elective time spent exclusively on independent study and/or board review **is not acceptable**.

International Health Electives
Each academic year, the institution sponsors up to four internal medicine residents and up to one emergency-medicine/internal medicine resident to each spend one 4-week rotation on an international health elective. There is a competitive selection process in the spring proceeding each academic year, and residents have the opportunity to apply for one of the spots.
The program has an academic exchange with a program in Bangalore, India, and San Jose, Costa Rica. Residents are encouraged to consider applying for elective time at one of these sites, but any international health elective with carefully documented structure and educational rationale will be considered. Residents in the Global Health Pathway have priority for three of the available slots each year. In addition, third year residents receive priority for international health electives, but residents from each training year are encouraged to apply. Funding is available for up to $1500 for international travel. See Michelle Herbers for an international travel packet and reimbursement paperwork **AT LEAST** 8-12 weeks prior to travel dates and plan to meet with the International Health Director, Dr. Ron Johannsen.

Out-of-State Electives
Due to administrative challenges regarding Medicare reimbursement and malpractice coverage, it is very difficult for the program to approve elective time spent outside the state of Minnesota. However, we recognize the importance of the opportunity for residents to participate in clinical care and/or research at an institution at which they are considering further training. Any resident who would like to pursue an elective at an out-of-state facility should contact the Program Director **at least 6 months** prior to their elective period.

Local Non-HCMC Electives
Many residents opt to spend elective time at a University of Minnesota based clinic or hospital. This is facilitated by the Office of Medical Education. Some residents elect to spend elective time at other facilities in the Twin Cities area (non-University based), for example, Planned Parenthood.

Continuity Clinics during Elective Periods
Residents should not cancel continuity clinic during their elective periods unless they have approval for an "away" rotation (outside of MN) **AT LEAST six weeks** prior to the beginning of the elective month. Refer to the Extended Leave Policy regarding arrangement of coverage for clinic related issues.

Residents spending elective time at other local facilities are expected to continue their continuity clinic sessions during their elective. Residents are encouraged to consider using the relative flexibility of this month to add additional continuity clinics if they are in need of additional time to "catch-up" with patients who've had difficulty getting appointments during residents' inpatient months.

SELECTIVE POLICY

We are also committed to allowing senior residents the opportunity to tailor a component of their final year of training, to address specific clinical deficiencies and/or prepare optimally for their specific planned scope of practice. The selective weeks are an opportunity to choose from a menu of **HCMC based clinical** opportunities not otherwise offered during the structured curriculum.
In order to maintain consistency of educational experiences and to document resident activities, the Medicine Education Office has developed a number of ambulatory clinic options for selectives: if they do not choose, they will be assigned to ambulatory clinics. Alternatively, residents are welcome to design their own selective rotation. All residents must do 8 out of 10 half days a week of clinical work and they can schedule what they want in the other 2 half days a week. In order to maintain consistency of educational experiences and to document resident activities, the Medicine Education Office requires a selective request form to be completed **at least six weeks** prior to the selective period. The Program Director must approve all selectives.

Continuity Clinics during Selective Periods
Residents may not cancel continuity clinic during their selective periods. As with electives, residents are encouraged to consider using the relative flexibility of this month to add additional continuity clinics if they are in need of additional time to "catch-up" with patients who've had difficulty getting appointments during residents' inpatient months.

EVALUATION OF RESIDENTS AND TRAINING PROGRAM

Evaluation of Resident Performance

The program is committed to the effective assessment of resident performance throughout the program, and to the use of this assessment to provide meaningful guidance and timely feedback to the residents. Through the Residency Review Committee – Internal Medicine's Educational Innovations Project, we are in the process of modifying our resident evaluation process. Over the next year, we will shift to a more compete portfolio model. With support and input from a faculty advisor, each resident will be responsible for documenting developing competency in each of the six general competency areas. While there are several mechanisms through which we currently assess resident performance, the core assessment occurs through the following ways:

Faculty evaluations (forms available for review in RMS):

1. Inpatient rotations: At the end of each 4 week rotation, faculty supervisors are required to provide written feedback to the residents with specific questions about their competence in each of the six core competencies. They also are expected to provide face-to-face feedback.
2. Continuity Clinic: Twice per year, the resident's core faculty preceptor in their continuity clinic Is asked to complete a written evaluation and use the form as the basis of a face-to-face session of feedback on resident performance.

Continuity Clinic Evaluations (forms available for review in RMS):

1. Continuity Clinic: Periodically, continuity clinic nurses evaluate each resident's competency in professionalism, communication skills, patient care and systems- based practice.

The faculty inpatient evaluations are available for resident review on-line upon completion of the evaluation. The faculty and continuity clinic evaluations are reviewed by the residents upon completion.

All of these evaluations are reviewed by the Program Director or an Associate Program Director with the resident at the Semi-Annual Review. They are also reviewed by the Clinical Competency Committee on a quarterly basis.

Patient Evaluations (forms available upon request from Michelle Herbers):

Continuity Clinic: Each year, we ask up to 25 of your patients to complete a confidential survey about their experience of your care. The survey tool is adapted from the American Board of Internal Medicine and is similar to tools that you will encounter in practice once you complete training. The results of this survey are provided for you in summary form each year.

Procedure for Appeal of a Negative Evaluation:

Each resident has the right to appeal any negative faculty or nursing evaluation. They may make an appointment with the Program Director or one of the Associate Program Directors to discuss the evaluation. This appeal will be formally noted in the resident file.

At the discretion of the Program Director and the resident, the resident can meet individually or in the Program Director's presence with the evaluating faculty member to discuss the evaluation.

Grievance Procedure for Adverse Action by Residency Monitoring Committee

In accordance with HCMC institutional policy described in HCMC Resident Reference Guide, residents have the right to appeal an adverse action recommended by the Residency Monitoring Committee. Attempts shall be made to resolve any grievance with those directly involved. Residents are encouraged

to work out grievances with their program director or chief of service. If the outcome is unsatisfactory to the resident, the resident can refer the grievance to the Office of the Medical Director. Residents who wish to remain anonymous may also bring grievances and complaints to their chief resident for resolution by the Resident Council or the appropriate party. Some items must be reported to the program director or medical director such as alleged harassment, suspected impairment or potential risk to patients or staff.

Resident Evaluation of Educational Experiences

Residents have the opportunity to evaluate the quality of their educational experiences. They are encouraged to provide informal feedback to the Medicine Education Office in an informal manner and are also regularly asked to provide such feedback in the following formal ways:

1. Medicine Resident Evaluation of Faculty and Training Experience (sample form on RMS): at the end of each 4 week rotation, residents complete an on-line evaluation of the effectiveness of their faculty supervisor and of the educational value of the rotation as a whole. These evaluations are released to evaluated faculty every 6 months. They are also reviewed by the Program Director, the appropriate Division Directors, and the Chief of Medicine. They are used for departmental performance evaluations and academic promotions, and for recommendations for attending assignments.

2. Resident Evaluation of the Continuity Clinic Experience (sample forms on RMS): every 6 months, the resident evaluates their primary faculty preceptor in continuity clinic and the clinic staff and systems. These evaluations are reviewed by the evaluated faculty, the Division Director, and the Program Director.

3. End-of-Year Resident Survey: The Graduate Medical Education Committee administers a confidential survey to all HCMC Internal Medicine Residents at the end of each academic year. This is separate from and in addition to the annual ACGME survey residents complete each year. This information is presented to the Medicine Education Office in aggregate and is used to design curricular change.

4. Semi-annual Review: an explicit purpose of the semi-annual review with the Program Director or an Associate Program Director is to provide a forum for direct feedback to the program leadership about any concern a resident has with the residency program.

RESIDENT SELECTION, EVALUATION, PROMOTION AND DISMISSAL POLICY

Our institution has formal procedures for the recruitment and appointment of residents that comply with the requirements listed below. Programs must monitor the compliance of each program with these procedures. To be eligible for a residency program at HCMC, all applicants must meet the following qualifications:

A. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).

B. Graduates of medical schools in the United States and Canada accredited by the American Osteopathic Association (AOA).

C. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:

   1. Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) or:
   2. Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.

D. U.S. citizen graduates from medical schools outside the United States and Canada who cannot qualify under "C" (noted above), but who have successfully completed the licensure examination in a U.S. jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted without further examination after successful completion of a specified period of graduate medical education.

E. Graduates of medical schools in the United States and its territories not accredited by the LCME but recognized by the educational and licensure authorities in a medical licensing jurisdiction who have completed the procedures described in paragraph "D" (noted above). Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school (U.S. or Canadian School).

Residents who meet the eligibility requirements and are selected by the faculty shall receive a contract confirming their appointment for one-year to the resident staff. Resident appointments are for a one year time period.

Resident Evaluation

Resident evaluation is the responsibility of the Program Director or his/her designee. A resident is evaluated at the end of each resident rotation by the medical staff and this is sent to the Program Director or his/her designee. In addition, other feedback to the Program Director or his/her designee may include the results of standardized tests, patient simulations, input from patients and other hospital staff. The Program Director or his/her designee must meet with each resident at least twice a year and, based on the resident's progress, may promote the resident to the next year of training. Residents may also be placed on suspension, probation or dismissed based on the judgment of the Program Director or his/her designee. Residents have access to an appeal mechanism and due process in accord with their contract.

Resident Promotion

All residents enter into annual contracts with Hennepin County Medical Center, regardless of the expected duration of their training program. Most training positions are ongoing "categorical" positions, while some programs may use a small percentage of "preliminary" or temporary slots. Residents in categorical positions will be promoted from each level of training after satisfying all requirements for that training level and offered subsequent annual contracts through program completion unless:

- They are dismissed or their contracts are not renewed based on academic performance which is below satisfactory;
- They are dismissed or their contracts are not renewed based on non-academic behavioral violations;
- They are ineligible for a continued appointment at the time renewal decisions are made based on failure to satisfy licensure, visa, immunization, registration or other eligibility requirements for training; or
- Their residency program is reduced in size or closed.

It is unlikely that existing residents will be displaced by a program closure or reductions. However, if this occurs, HCMC will make every effort to assist the residents in locating another training program where they can continue their education.

Resident Dismissal

A. **The following actions shall entitle the resident to a hearing upon timely and proper request.**

1. Non-renewal of contract;
2. Suspension of over 30 days from residency program; or
3. Termination from residency program.

B. **Prior to the imposition of any action which entitles a resident to a hearing, the resident shall be given written notice which:**

1. States the specific grounds upon which the action is based;
2. Advises the resident of the opportunity to meet with the Residency Director, Department Head or his/her designee;
3. Advises the resident of his/her right to request a hearing;
4. Informs the resident he/she has 14 days, after receipt, to request a hearing;
5. Informs the resident a written request for hearing is to be directed to the Medical Director; and
6. States that failure to request a hearing constitutes waiver of all rights to appeal.

C. Following the receipt of a request for hearing the Medical Director shall convene a hearing panel consisting of one member of the medical staff and one resident.

D. The appeal hearing shall be informal as opposed to an evidentiary hearing. At the appeal, the resident shall have the right to an advisor, who may be a fellow resident, faculty member, an attorney or any other advisor of the resident's choosing.

E. The resident and program director shall have the right to present information, including written or oral statements from individuals whose attendance he/she is able to arrange if pertinent to the issues at hand. Personal attendance of fact evidence is preferred so that questions may be asked.

F. The panel shall have the right to adopt, reject, or modify the previous decision and shall make a recommendation to the medical director. The medical director shall make a final decision and notify the resident and program director of his/her decision in writing.

G. The medical director's decision shall be final. No further appeal process is available.

The Medical Center and the resident's department shall impose immediate suspension upon a resident if they determine that the resident's continued participation in the program is detrimental to patient safety or the delivery of quality patient care**.**

INPATIENT SERVICES: POLICIES AND PROCEDURES

CARDIOPULMONARY ARREST PROCEDURES

HCMC ARREST TEAM

PURPOSE: Provide timely, consistent, and appropriate response to medical emergencies that occur within the medical center.

I. Members of the Arrest Team (CODE team)

A. Physicians
   1. Staff physician (Chief resident or hospitalist) to provide oversight
   2. All on-call medicine residents available on all teams.
   3. A senior Surgery resident will also respond to arrests and provide assistance with any necessary procedures.

B. Respiratory Therapist

C. ICU staff nurse (CCU, MICU or SICU)

D. Nursing Supervisor

E. Nurse Anesthetist

*Note: Due to concerns for overcrowding, **students** are asked to NOT enter the room during a code unless specifically asked.*

II. Guidelines for Arrest Team Members

A. Each member of the arrest team will be oriented to: Use of the code beepers (admission pager), location of HCMC departments, specific roles of arrest team members, and location and use of emergency equipment.

B. Team members will respond to all emergency situations, including all intensive care units and patient care areas, and will be individually excused from the area if not needed.

C. Team members should respond STAT to all emergency pages.

D. The code beeper will be passed from arrest team member to arrest team member to ensure continuous coverage. The beeper will be passed on at the end of the team member's shift and at any time the team member determines he/she is unable to respond in a timely manner to a code page.

III. Arrest Team Beepers (Code Beepers)

A. Each of the Medicine service admission pagers receives CODE pages. Initially, residents will be paged with the message "1111" followed by a later page with the specific location of the code.

B. Beepers carried at all times by arrest team members, in addition to beepers carried for normal communications.

IV. Roles of Arrest Team Members

A. Physicians:

For all emergency situations that involve inpatients, the patient's primary physician will direct the resuscitation efforts. In the absence of the primary physician, the arrest team physician will be in charge until the arrival of the primary physician. The code team leader should identify themselves and run the code.

If the arrest victim is a surgery patient, the Surgery resident will direct the resuscitation efforts with the assistance of the Medicine residents (i.e., line placements, blood draws, monitoring rhythm). If the arrest victim is not a surgery patient or is not a patient, the Medicine resident will direct the resuscitation efforts with the assistance of the Surgery resident.

B. Nurse Anesthetist: Performs intubation as needed.

C. Respiratory Therapist: Maintains airway and ventilates patient, sets up respiratory equipment.

D. ICU Staff Nurse:

Note: If the arrest victim is a patient in a unit or team center, or in an outpatient clinic, the patient's assigned nurse will maintain primary nursing responsibility for the patient.

The ICU staff nurse will prepare medications, IV set-ups, and syringes for blood draws; assist with the monitor/defibrillator; and act as a resource regarding the location of specialized equipment that may be requested.

E. Off-shift, weekend, or holiday: Nursing Supervisor

1. Page additional personnel to location, if necessary.
2. Act as recorder, if no other personnel available.
3. Notify unit of impending transfer, as appropriate.
4. Assist with family members.

F. Security Guard: For emergencies occurring in non-patient areas, a security guard will be paged to the scene by the operator. The guard will bring a stretcher to the scene for transport to an ICU or to the ED.

V. Procedure for Emergencies on Inpatient Areas (Team Centers and ICUs)

A. Management of cardiopulmonary arrest prior to arrival of arrest team.

1. Initiate resuscitation in accordance with the recommendation of the AHA for witnessed or unwitnessed cardiopulmonary arrest. If alone, summon help while initiating CPR.

2. Nurses will likely be the first medical personnel on the scene of an arrest and will be responsible for initiation of CPR until the arrival of the arrest team.
3. Activate the emergency paging system by calling x116. Inform the operator of the arrest and its location. ICU areas should push the red emergency button on the life support column. STATE THE RESIDENT IN CHARGE OF THE PATIENT.

4. The emergency operator will
   a. Activate the code beeper paging system, causing the simultaneous paging of all arrest team members, and
   b. Overhead page "Code Team to (location)". The page will be repeated twice, thirty seconds apart.

5. All inpatient nursing personnel from the area being paged that are off the floor should return to the area immediately.

6. A staff member from the areas should assist the person discovering the arrest by bringing emergency equipment to the bedside, placing the cardiac board beneath the patient, and applying the monitor leads.

7. If the area does not have its own defibrillator, the defibrillator designated for use in the area should be brought to the scene by a staff member of the department, which maintains the defibrillator.

B. Management of cardiopulmonary arrest upon arrival of arrest team.

1. The primary nurse will remain at the bedside, summarizing events leading to the arrest and patient history, administering medications, and checking vital signs.

2. The appropriate arrest team physician will assume charge of the arrest, identify roles of the team members, and dismiss arrest team members that are not needed.

VI. Procedure for Emergencies on Outpatient and Non-Patient Areas

A. Management of cardiopulmonary arrest prior to the arrival of arrest team.

The person discovering the situation should initiate resuscitation in accordance with the recommendations of the AHA for witnessed or unwitnessed cardiopulmonary arrest. If alone, summon help while initiating CPR.

CARE OF NON-TEACHING PATIENTS: RESIDENT RESPONSIBILITIES

As of July 1, 2005, a staff physician only hospitalist service began admitting patients to the HCMC Internal Medicine Service. The residents' service responsibilities for these non-teaching patients are limited by institutional policy.

As described in the Hennepin County Medical Center Medical Staff Bylaws, Policy #120050, except in an emergency, residents' service responsibilities shall be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility.

CONSULTATION BY AND FOR THE DEPARTMENT OF MEDICINE: GUIDELINES

A. General Medicine consults to non-Medicine services

General Medicine consultations are primarily handled by the Hospitalist Service. The residents on Medicine Inpatient nightfloat coverage will work with the overnight hospitalist for new General Medicine Consults overnight.

A hospitalist is on call at all times and should be made aware of **all** consults. In addition, residents and staff physicians are available for subspecialty consultations 24 hours a day. Please take advantage of their services when appropriate.

B. Subspecialty Medicine Consultations

1. The request for subspecialty consultations will be initiated by the referring resident/staff by calling the resident on call for the subspecialty service. An order in the electronic health record is required, indicating which Medicine subspecialty is being asked for consultation (including General Internal Medicine, Cardiology, Nephrology, Pulmonary, Infectious Disease, Gastroenterology, Endocrinology, Rheumatology, and Hematology/Oncology).

2. Emergent night, weekend, and holiday consultation requests should be transmitted directly to the resident on call, who will involve the appropriate Medicine subspecialty service. The Medicine Chief Resident on call can be reached through the hospital telephone operator or via pager if there are problems with obtaining consultation.

C. The responsibilities and obligations of the Medical Consultant are as follows:

1. Non-emergent consultations are to be completed within the working day in which the request is received whenever possible, but in any case, ***no later than 24 hours after receipt of the consultation request*** by the Consulting Service.

2. After examination of the patient, the resident consultant may enter the preliminary consult into the patient's electronic health record. Emergent recommendations should be communicated directly to the patient's treatment team.

3. In all cases, the consultation should be checked by appropriate staff, and the formal consultation note annotated/verified with appropriate documentation ***within 24 hours*** after the patient has been seen by the Consulting Resident Physician.

4. *The Consultant Resident should contact the referring resident* on completion of the consultation, directly convey the recommendations made, and answer any questions the referring resident may have.

5. In the case of emergency consultations, the patient should be seen immediately (when indicated, by both the consulting resident and staff) and the recommendations conveyed directly to the referring resident immediately after examining the patient. The consult note should also be completed at that time by both resident and staff.

6. The completed Consultation form is a permanent part of the patient's record. If the patient is seen subsequently by the consultant, additional comments and recommendations should be recorded as Progress Notes in the chart.

D. General Considerations

The Consultant has a great deal of responsibility, and at times the Consultant's recommendations and appraisal of the problem determines the outcome and prognosis of the patient's illness. The thoroughness and quality of the consultation rendered reflects not only on the individual, but the entire Department of Medicine. It is a privilege and a distinction to be asked to give consultation to a physician colleague.

Remember: when you leave HCMC, your career and your livelihood may depend on your ability to attract and hold a large base of physicians using you as a consultant***. Please be thorough, thoughtful, serious, and gracious as a consultant now.***

DELINQUENT AND INCOMPLETE CHARTS

JCAHO requirements and the continued financial solvency of Hennepin County Medical Center necessitate the **completion of medical charts prior to discharge of the patient from the hospital.**

Medicare regulations also require that the attending physician "attest in writing to the principal and secondary diagnoses, and names of the procedures performed" before any billing for hospital services can be done.

If the occasion should arise when discharge summaries, etc. cannot be done prior to the time of discharge, it is absolutely essential that they are done and the chart finished (including signatures) within 5 days of discharge.

All dictations will be available to cosign within the Epic inbox.

A list of delinquent and incomplete charts will be forwarded to you and your attending for PROMPT attention. A complete list is also forwarded to the Program Director on a weekly basis.

Any resident that has a chart on the delinquent list (over 30 days after discharge) will receive a reminder letter from the Medical Director. If any chart remains delinquent after that reminder, the resident will receive a reminder telephone call. One week after the reminder telephone call, if the resident has any remaining delinquent charts, their cafeteria meal card will be inactivated, making them unable to purchase food through their residency account.

Any resident with a chart on the delinquent list despite letter and telephone reminders and deactivation of their meal card will receive a call from the Office of Medical Education. The charts must be completed within 3 business days of that second reminder telephone call, or the resident will be pulled off-service and required to complete their charts before being allowed to continue in the program. The back-up system will be activated, requiring that another resident be called in off of sick call to cover for the resident with delinquent charts.

LIMITATIONS OF RESIDENT SERVICE: ADMISSION AND CENSUS CAPS

It is the responsibility of the program director to ensure that the residency does not place excessive reliance on residents for service as opposed to education. One component of this is the program policy limiting the number of new admissions per resident, and the number of patients for whom residents provide ongoing care.

These limits are the following:

ADMISSIONS

1. PGY1: No more than 5 new admissions per day, plus an additional 2 *if they are in-house transfers from the medical services*
2. PGY2/3: When supervising more than one PGY1, the supervising resident must not admit or supervise admission of more than 10 new patients and 4 transfer patients per admitting day

ONGOING CARE

1. PGY1: No more than 10 patients
2. PGY2/3: *When supervising one PGY1,* no more than 14 patients. *When supervising more than one PGY1,* no more than 20 patients

In the event that a team reaches a census limit, it is the responsibility of the attending physician and the chief residents to redistribute patients to a staff-only team or another ward team to ensure compliance.

LIMITED CARE PLANS

Policy/Purpose: In some situations, it is appropriate to forego (withdraw and withhold) life-sustaining treatment. This policy and procedure is adopted to assist patients, patient representatives, and staff in implementing such a decision.

Statement of Principles:

1. The patient has the legal and ethical right to and the primary responsibility for self-determination, including the right to forego (withhold and withdraw) treatment. There is no legal or ethical distinction between withholding and withdrawing treatment.

2. When a patient lacks the necessary decisional capacity to participate in treatment decisions, such decisions will be made on behalf of the patient by the patient's representative. To the extent possible, the patient shall be included in these decisions. Decisions made by the patient's representative shall reflect the patient's wishes as previously expressed. If the patient's wishes are unknown, the decision shall reflect the patient's best interests.

3. Whenever the decision to forego life-sustaining treatment is made, the patient shall receive care that maintains dignity and comfort.

4. As with any plan of care, the patient's condition shall be reviewed periodically to assure that the decisions, the plan of care, and implementation of that plan continue to be appropriate.

5. When there is a decision to forego life-sustaining treatment, even when the patient's or patient representative's decision and the decision-making process are consistent with medical, legal, and ethical standards, the patient/patient representative and/or staff may have concerns regarding the appropriateness of a course of action. When this occurs, HCMC shall provide mechanisms to address these concerns.

6. The attending staff physician or other health care providers are not obligated to comply with the patient's decision if the treatment would be contrary to accepted standards of clinical practice or the law. Furthermore, in cases where implementing the patient's decision would be contrary to the deeply held personal or professional beliefs of the attending physician or other health care provider, that individual has the right to withdraw from the patient's case. Should such a conflict occur, the patient shall not be abandoned, but rather, shall be assisted by the physician and HCMC staff in obtaining care that is consistent with the patient's wishes.

Procedure

I. Determining the Decision Maker

A. Patient with decisional capacity. If the patient has the necessary decisional capacity, the patient shall make all treatment decisions. A patient has decisional capacity if the patient has the ability to understand, reflect upon, and reiterates the medical situation, including the consequences of the decision to forego treatment. Decisional capacity may be presumed in the absence of any impairment of judgment. The attending physician usually determines decisional capacity. The physician may consult other health care providers, family members, or others who know the patient to determine the current level of decisional capacity.

B. Patient without decisional capacity. In those instances in which the patient lacks decisional capacity, the patient's representative shall make the decision regarding foregoing life-sustaining treatment. In the usual order of priority, the following individuals may act as the patient's representative:

1. In the case of a minor, the child's parents or legal guardian.

2. In the case of an adult:
   a) The agent, if the patient has a valid durable power-of-attorney for health care;
   b) The proxy, if the patient has a valid living will;
   c) The legal guardian with responsibility for health care decisions;
   d) The spouse;
   e) An adult son or daughter;
   f) Either parent;
   g) An adult brother or sister;
   h) Other close family members; and
   i) In some circumstances, a close personal friend of the patient.

3. If a patient does not have a representative to make a decision on the patient's behalf, does not have an Advanced Directive, and there is no other reliable evidence of the patient's wishes, the attending physician shall contact the Ethics Committee.

II. The Decision-Making Process

A. The attending physician shall ensure that the patient or the patient's representative making the decision understands the following before the decision to forego life-sustaining treatment is made:

1. His or her current medical status, including the likely course of the condition if treatment is withheld or withdrawn;

2. The interventions that might be helpful to the patient, including a description of the treatment options, their risks, and anticipated benefits and burdens, and

3. The attending physician's professional opinion regarding the available alternatives.

B. In the case of the patient without decisional capacity, the decision regarding treatment shall be consistent with the stated directives of the patient as expressed in an Advanced Directive or, if there is no Advanced Directive, the decision shall be consistent with other reliable expressions of the patient's wishes, the decision shall be in the best interests of the patient, taking into consideration the patient's values, life philosophy, and/or spiritual beliefs.

C. Throughout the decision-making process, the attending physician is encouraged to consult with his or her colleagues and other members of the health care team.

D. When a decision to forego treatment has been made, the attending physician shall communicate the decision to the other members of the health care team.

E. If at any time during the decision-making process questions or concerns arise, see Section V.

III. Documentation

A. When the participants have reached a decision to forego life-sustaining treatment, the attending physician shall document the decision in the patient's medical record. Documentation should include:

1. Participants in the discussion.

2. Who the decision maker is.

3. If the patient is determined to lack adequate decisional capacity, the rationale for determining decisional capacity.

4. Summary of the information presented and the discussion, which led to the decisions.

5. Specific decisions reached, including treatment to be continued and treatment to be withheld. Considerations should include, but not necessarily be limited to, ventilation, blood products, medication, hydration and nutrition, dialysis, and other interventional procedures.

IV. Development and Implementation of the Care Plan

A. The care plan shall particularly address ongoing assessment and management of pain and psychological stress. In addition, the plan shall be documented in the medical record and shall include:

1. The patient's resuscitation status and an order if the patient is to be DNR/DNI.

2. Orders for what specific treatments will be withheld and/or discontinued. Treatment options to be considered include:
   a) Intubation and ventilatory assistance
   b) Oxygen
   c) Dialysis
   d) Blood products
   e) Diagnostic lab tests and x-rays
   f) Medications (i.e. antibiotics, pressors, etc.)
   g) Nutrition and hydration

3. The plan shall address maintenance of dignity, comfort, and hygiene and shall contain mechanisms to insure that patient and family members are not abandoned, but have access to ongoing communication with the staff.

4. Orders for medication:

    a) The goal of treatment is to relieve pain and suffering to the fullest extent possible, consistent with the patient's wishes.

5. Health care professionals must make every effort to relieve the pain and suffering of the dying patient. Relief of pain and suffering may require either intermittent or continued administration of large doses of analgesics and sedatives which, in circumstances other than anticipated death, would be considered inappropriate. Dying patients should be assured the maximal possible comfort, even in the face of impending death, as heralded by falling blood pressure, declining rate of respirations, or altered level of consciousness. Vital signs may be obtained to assess the patient's status in the dying process, but should not influence decisions about administering medications in the presence of continued pain or other distressing symptoms for which the medication is an accepted treatment. The attending staff physician shall clearly document in the patient's chart all clinical indications for administration of medication, including all dosage changes.

6. Neuromuscular blocking agents are generally excluded from these medications as they have no therapeutic value in relief of pain and suffering and their use precludes assessment of pain and suffering. Before ventilator support is decreased or discontinued, neuromuscular blocking agents should be discontinued. No effects of neuromuscular blocking agents, as evidenced by a train of four repetitive stimulations, should be discernible prior to discontinuation of ventilator support in this context.

V. Decisions Which Result in Concern or Conflict

A. The attending physician, patient/patient representative, or other health care provider may seek an Ethics consultation when a concern or conflict remains after a reasonable attempt to resolve any of the following:

1. Who the decision maker should be;
2. The decision making process; or
3. The plan of care.

NON-RESUSCITATION POLICY

Definition:

DNR/DNI (Do Not Resuscitate/Do Not Intubate): In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitative measure will be initiated.

Guidelines:

A comprehensive evaluation of the patient's medical condition is necessary before consideration of the DNR/DNI order.

The ward team in consultation with the attending staff physician shall determine the appropriateness of the DNR/DNI order for an individual patient.

DNR/DNI orders ARE compatible with maximal therapeutic care. The patient may be receiving vigorous medical support and yet justifiably be considered for DNR/DNI order.

When the patient is competent, the DNR/DNI decision will be reached consensually by the patient and physician. When the patient is incompetent, this decision will be reached consensually by appropriate family member(s) and the physician. If a competent patient disagrees, or, in the case of an incompetent patient, the family member(s) disagree, a DNR/DNI order will not be given.

Implementation:

Once the DNR/DNI decision has been made, this directive will be placed as a formal order by the house staff. It is the responsibility of the house staff to ensure that this order and its meaning are discussed with the other medical personnel involved in the care of the patient.

The basis for and considerations relevant to this decision shall be recorded by the G2/G3 resident in the progress notes. The attending staff physician, or other staff physicians involved, shall place a note in the chart, indicating concurrence with the DNR/DNI decision. In addition, the staff physician must co-sign the DNR/DNI order in the chart.

The DNR/DNI order shall be subject to review on a regular basis and may be reversed at any time.

LINES OF RESPONSIBILITY FOR RESIDENTS AND ATTENDING PHYSICIANS

Inpatient Ward Rotations

ATTENDING PHYSICIAN
Supervision of all orders and treatment plans
Daily examinations of each patient on census
Organization of teaching responsibilities

↓

SENIOR RESIDENT (PGY2 or PGY3)
Review of PGY1 daily assessment and plan – negotiation with attending for final therapeutic plan
At least daily examinations of each patient
Supervision of PGY1 review of all laboratory and radiology results
Discussion of therapeutic plan with consulting physicians
Direct teaching of interns and medical students
Written and verbal sign-outs to on-call team each day
Oversees communication with patients' primary care physicians

↓

INTERN (PGY1)
Initial assessment of new patient admissions
Daily progress note on each primary patient
At least twice daily examinations of each primary patient
Review of all laboratory and radiology results
Writes all orders on primary patients charts
Written & verbal sign outs of patients (& medical student patients) to on call team on senior resident's day off

↓

Consult Rotations: Residents rotate with peers at the same level of training on consult rotations. Therefore, there is no supervision of resident by resident, but rather only of resident by attending physician.

ATTENDING PHYSICIAN
Supervision of all orders and treatment plans
Daily examinations of each patient on census
Organization of teaching responsibilities

↓

RESIDENT (PGY1, 2 or 3)
Initial assessment of new patient consultations
Daily progress note on each patient for whom new recommendations are indicated
At least daily examinations of each patient
Review of all laboratory and radiology results
Direct communication with primary team

ORDER WRITING POLICY

Admission Orders:

Admission orders must be entered in a timely fashion on all patients admitted to the Medicine wards. Admission orders must be entered within one hour on all patients admitted to the MICU, CCU, or PCRC.

Consultants:

Resident and staff physicians acting as consultants on inpatients will enter treatment recommendations in the consult note, but will not enter orders in the chart unless given permission to do so by the primary team. Under emergency situations, the consult team may enter orders.

Responsibility for Orders:

Medical student orders must be co-signed by the G1 or G2/G3. Fellows, consultants, and Chief Residents may enter orders with the permission of the primary ward resident, or in emergency situations. Attending physicians are legally responsible for all orders written, but they generally do not write orders except in emergency situations.

Verbal/Telephone Orders:

In 2005, HCMC adopted a policy to minimize the number of verbal and telephone orders given, because they are recognized as a practice with high risk for medication errors. Therefore, voice orders should not be given whenever a physician has reasonable access to an electronic health record.
When a verbal or telephone order is given, nurses should read back the full order to ensure clarity. Nurses may also request that the physician sign the order as soon as possible. The ordering MD must sign telephone/verbal orders within 24 hours of the order.

Transfer Orders:

Transfer orders must be written on all patients transferring from intensive care units to wards, from wards to intensive care units, and from one service to another. Residents should be aware that nurses have the right to request full admission orders on transferred patients, especially those who are transferred from a higher level of care. There are often inappropriate orders that need to be addressed once the patient transfers units.

PATIENT DEATH PROCEDURES

Autopsy Consent

A death note must be written in the chart after the death of a patient on the Medicine service. The note should include time of death and absence of vital signs, breath sounds, cardiac activity, and neurologic activity.

Every reasonable effort should be made to obtain the consent for autopsy when a patient expires. If the G1 resident encounters difficulty obtaining consent, the G2/G3 resident should be notified. In those instances where an autopsy examination permit cannot be obtained, the G2/G3 resident will write a death summary on the patient's chart. If the death is a medical examiner's case, no request/consent need be obtained from the next-of-kin.

When an autopsy is performed on a patient who has died while under the care of the Medicine Service, the pathologist performing the autopsy will review the chart, determine the staff and resident physicians caring for the patient at the time of death (both primary team and covering team), and send them a copy of the autopsy report. All autopsy reports on patients cared for on the Internal Medicine Service are forwarded to the Program Director. The program director reviews the chart and forwards reports to residents who provided care for the patient during the hospitalization.

Death Certificates:

THE STAFF PRIMARY CARE PHYSICIAN (I.E. THE PATIENTS CLINIC DOCTOR) AT THE TIME OF DEATH IS RESPONSIBLE FOR COMPLETING THE DEATH CERTIFICATE.

Organ only or organ and tissue donation procedures:

Primary MD confirms brain death and introduces donation to family**

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Chaplain called (pager: 336-0410)

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Primary RN Notifies Transplantation Services (651) 291-4654 - Outside Organ Procurement Agency

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Donor referred to LifeSource

↓

LifeSource initiates donor evaluation

↓ ↓

No contraindications

↓

LifeSource notifies Medical Examiner

↓

LifeSource personnel discusses details of donation with family (Chaplain present)

↓

Family consents to donation →

↓

LifeSource obtains consent and medical history (copies left on patient chart) & documents on patient chart compliance with requirement that donation be requested

↓

LifeSource facilitates organ/tissue harvest

↓

Contraindications Present

↓

LifeSource documents on patient chart compliance with the requirement that donation be requested

Family refuses donation

↓

LifeSource documents refusal on patient chart

**The Joint Commission for Accreditation of Health Care Organizations (JCAHO) and Federal and State laws require that all deceased patients be assessed for possible organ and/or tissue donation. It is the responsibility of the medical team to

Organs/tissues harvested documented on patient chart	inform the donor family of the option to donate and to allow them to make a decision with which they are comfortable.

PATIENT DISCHARGE FROM THE MEDICINE SERVICE

Discharges are to be approved by the senior resident and attending physician. The order to discharge a patient from the medicine service should be entered as early as possible on the day of discharge, with the goal of having discharge orders in by 11am.

Patients discharged to a nursing home must have an electronic discharge summary completed prior to hospital discharge.

The senior resident is responsible for ensuring a discharge summary is completed on each patient hospitalized. When the patient is discharged within 48 hours of the resident service change, it is recommended that the former resident complete the discharge summary (or complete off-service transfer of care notes when transferred to the floor or to another service).

Outpatient Follow-Up:
Patients admitted to the medicine inpatient service become the responsibility of the Medicine Department for long-term ambulatory management. Exceptions to this rule include patients who have an alternate primary care resource at the time of their admission and patients who choose an alternate primary care source, or who elect not to be followed after hospital discharge.

When a patient without a primary care provider is discharged, **it is expected that the patient will be set up for a "new patient" visit in the Medicine Clinic as soon as possible after discharge.**

Nursing home discharges
The notification and summary guidelines for discharging HCMC patients to a nursing home need to be closely followed to avoid confusion and subsequent errors.

It is essential in the care of these patients that the following guidelines by followed in all cases.

1. The Clinical Coordinator and Social Working will coordinate nursing home discharges with the appropriate nursing home staff and notifying Extended Care of a pending discharge if necessary.

2. No patient may be discharged from HCMC without a discharge summary accompanying the patient to the nursing home and a copy of the summary being immediately available to Extended Care.

    a. Health Unit Coordinators will be responsible for transmitting copies of the discharge summaries to the Extended Care office by the day of discharge.

PATIENT TRANSFER AND TRANSPORT POLICIES

PATIENT TRANSFER POLICIES

ICU:

In the event that conflict or confusion arises, the senior residents, ICU fellow, and attending physicians are responsible for approving admissions into and transfers out of the Medical Intensive Care Units (MICUs). If any of the consulting services are in disagreement on the movement of patients from this unit, they should confer first with the ICU Fellow, then with the ICU staff physician. If the problem cannot be resolved, it should be brought to the Internal Medicine Chief Resident, and then the Program Director's attention. The Program Director and the appropriate Medical Director of the ICU will adjudicate the problem.

Service Transfers:

Patient transfers from other services (surgery, orthopedics, OB/GYN, etc.) must be approved by the Medicine Chief Resident or the attending physician. Admissions personnel have been informed not to accept transfers to Internal Medicine services from anyone other than the Chief Residents.

ICU to Ward Service Transfers:

1. The accepting inpatient team should be called once a bed has been assigned on ward, and prior to transfer out of ICU to the wards
2. Senior residents on MICU service should call the accepting team about the transfers out of the MICU. A G1 should only call in the transfer if the G2/3 is off that day.
3. The primary ward team (or admitting team if evening or night) is responsible for meeting the patient and providing ongoing cares at the time the patient arrives to the ward.

TRANSPORT OF CRITICALLY ILL PATIENTS:

All critically ill patients transported from the Medicine Clinic or Emergency Room (including those with the diagnosis of acute myocardial infarction) will be *accompanied* by a physician (the physician will **NOT** be the primary transporter). In most cases, the G1 or G2/G3 resident on the primary medicine service will be the responsible physician. If these residents are not available, the physician admitting the patient from the Medicine Clinic will accompany the patient to the intensive care unit/coronary care unit.

It is not the responsibility of the emergency medicine resident to supervise a patient in the stabilization room of the Emergency Department while awaiting a bed; however, medicine residents are expected to monitor admitted patients in the CT scanner enroute to the Medical ICU or CCU. Patients who are being admitted from the stabilization room ALL require a resident for transport, regardless of their destination.

Patients admitted with a cardiac diagnosis (acute myocardial infarction, arrhythmia) will be monitored during transport with the Life Pack equipment. Medicine Clinic nursing personnel will remain with the patient until the patient is physically bedded down in the intensive care unit or coronary care unit. Clinic personnel are responsible for transporting equipment back to the Medicine Clinic. All patients admitted to the intensive care unit will be transported by stretcher.

PROCEDURES

Documentation of Procedures

Correct documentation of procedures is critical for the Department of Medicine and hospital administration to meet JCAHO requirements. In addition, the accuracy of the resident's own records is important. This information is necessary for compliance with the RRC-IM and ABIM. It is often requested by prospective employers and is required for licensure in Minnesota and in other states.

To Document a Procedure:

1. Complete a note in Epic to ensure proper billing.
2. Use new-innovations.com (Residency Monitoring Suite) to document procedures for your records. **This will be information required by your potential employer or fellowship program.**

Supervision/Certification:

Until you are certified, all procedures must be supervised by either a resident who is certified in that procedure, or by a staff physician. Completed procedure forms should be co-signed by the resident or staff supervising the procedure, and turned in as noted above. The Program Director or his/her designee will review these forms and determine eligibility for credit for the procedure. An updated procedure summary will be available to you at least quarterly. This procedure summary will also be evaluated quarterly as part the evaluation of clinical competence by the Resident Monitoring Committee.

The number of procedures required to obtain certification will vary. Please see the required number listed next to each procedure on the sample Procedure Summary.

Successful performance of a procedure includes all of the following criteria:

1. Knowledge of the indications and contraindications for the procedure.
2. Knowledge of potential risks of procedure & ability to clearly explain these risks to the patient.
3. Technical proficiency to complete the procedure.
4. Ability to anticipate and handle potential complications.
5. Appropriate documentation of the procedure.

Procedures that have special requirements:

Angioplasty/Intra-Aortic Balloon Pump:
Patient management related to coronary artery angioplasty or intra-aortic balloon pump therapy will be directed by the Cardiology Fellow or Cardiology attending physician

Cardiac Surgery-Related Patient Management:
Patient management relating to cardiovascular surgery will be directed by the Cardiology service in conjunction with the CVP Surgery service.

Cardiopulmonary Arrest:
A cardiopulmonary arrest team has been established to supervise/manage all arrests in the hospital.

Cardioversion of Atrial Arrhythmias (elective):
All elective cardioversions will be personally supervised by a G3 cardiology resident and either the Cardiology Fellow, Chief Medicine Resident, Critical Care Fellow, or Cardiology attending staff.

Swan Ganz Catheters:
All Swan Ganz catheters must be supervised by a G4 resident (or above) or staff.

In the event of a complication resulting from attempted central vein puncture or attempted arterial line placement, the Chief Resident or Director of the MICU or CCU must be notified within two hours of the incident.

Temporary Pacemakers:
All temporary pacemakers will be supervised by a Cardiology Fellow, Critical Care Fellow, or Cardiology attending physician.

SICK CALL AND JEOPARDY/BACK-UP COVERAGE

A back-up policy is necessary to cover services in the case of an unplanned absence due to illness, emergency, etc. The chief residents will keep track of number of sick days each resident takes. All residents are **required to notify the chief residents when they miss a day, on both inpatient and consult/outpatient services.** After more than three consecutive missed days, a resident will require a physician's note and approval from the residency program director. After a total of three sick days/year, a resident will be expected to repay those days during available weekends and/or elective time as needed to cover fellow residents

There is a Jeopardy system in place to provide coverage for most short term coverage needs. However, there are still circumstances when additional coverage is needed. This additional coverage is provided from double covered consult blocks, and occasionally elective/selective blocks as well. The Chiefs will notify residents responsible for back-up coverage as early as possible.

In general, the following services will be utilized to provide emergent coverage if the Jeopardy resident is unavailable:

G1: Ambulatory, Endocrine, Geriatrics, and Behavioral rotations.
G2/G3: Pulmonary, Rheumatology, ID, GI, and Hematology/Oncology rotations

Back-up responsibilities take precedence over ALL OTHER DUTIES (including moonlighting). Residents on all non-call rotations are at risk for back-up.

Providing back-up is part of your resident responsibilities, and therefore is not reimbursed as a moonlighting shift, nor is the absent resident responsible for paying back a shift.

Back-up is designed for short-term absences. Coverage for absences for longer than 2-3 days will be at the discretion of the Chief Residents.

G1s cover their own residents. G2s and G3s are a common pool to cover back up needed for both classes. A record will be kept of those residents who were utilized for back-up.

LEAVE POLICIES

EXTENDED LEAVE POLICY

BACKGROUND:
Extended leaves during residency training affect multiple aspects of the operation of the residency program. The effects are often complex and require a large amount of foresight and planning to make the process as smooth as possible, particularly for clinic scheduling. This policy is intended to help residents and administrative staff to navigate that process.

TYPES OF LEAVE COVERED:
This policy is intended to address any leave taken for **academic or personal purposes.** Examples would include extended periods out of the state or country for research electives, absences related to personal or family illness, or maternity/paternity leave.

PARAMETERS FOR PAID AND UNPAID LEAVE:
A Family Medical leave of absence for serious illness of the resident, serious health condition of a spouse, parent or child, or birth or adoption of a child, shall be granted through formal request to the Program Director. The length of the leave will be determined by the Program Director based upon an individual's particular circumstances and the needs of the department, but shall not exceed 12 weeks in any rolling 12 month period (12 months from the date the leave begins). Minnesota Statute requires that an employer allow up to 6 weeks of unpaid leave of absence.

The resident shall be granted up to six weeks PAID maternity leave and up to two weeks PAID paternity leave. For maternity leave, two weeks will be paid by Hennepin County Medical Center and four weeks will be paid by short-term disability. After the six weeks of paid leave and any vacation time accrued, additional time will be without pay. During the unpaid portion of any leave, the resident may be required to pay full medical insurance premiums. Following adoption of a child, a resident shall be entitled to two weeks of paid parental leave.

The resident shall inform the Program Director and Program Coordinator as soon as possible of any Family Medical Leave to allow scheduling of curriculum plans to accommodate the leave. It is the responsibility of the resident and the Program Director to ensure that Board eligibility requirements are met within the original residency period or that alternative arrangements are made.

If a resident has unused vacation time, s/he may elect to extend the period of paid absence by using vacation time. This would allow for a maximum of nine weeks' paid leave at any given time (6 weeks by policy + up to 3 weeks of vacation.)

Residents who wish to extend a family leave beyond the paid period may submit a written request to the program director. Extended leave **up to 3 months total** will be granted at the discretion of the Program Director and the Chief Residents based on the program's ability to manage clinical responsibilities with a limited cohort of residents.

There are two important caveats to this policy:

1) Any unpaid leave time that is taken must be made up at the end of the residency program, with clinic responsibility included. This cannot be made up in elective time.
2) A total of four months of leave is allowable throughout the three-year residency, except under special circumstances to be determined by the Program Director and Chief Residents.

LEAVE DUE TO MAJOR ILLNESS
A major illness is defined as a continuous absence from service for more than 7 calendar days. For a continuous absence due to personal illness or disability while under the care of a physician, full pay will be provided for an additional 21 calendar days beyond the normal 7 days of sick leave (28 days total). For more information, please refer to the Resident Leave Policies section in the OMD Resident Handbook on the RMS home page.

PERSONAL LEAVE OF ABSENCE

A resident may arrange with the Program Director for a personal unpaid leave of absence. The resident shall continue to be included in health and disability insurance policy for up to three months, but will be responsible for payment of the premiums. Arrangements for premium payment shall be made with the payroll manager. Responsibility for meeting the certification requirements of the relevant American Board rests with the individual resident and Program Director.

CLINIC SCHEDULING:

The RRC mandates that residents are expected to continue their primary care clinics during extended absences except under the following conditions:

1) Out-of-state academic leave (e.g., research, conferences)
2) The paid portion of FMLA leave
3) Vacations

In all other situations, it is the expectation of the program that the resident make arrangements with his/her clinic staff and Barb Boyer/Dawn Imme to ensure that patients can be seen for regularly scheduled visits and for any acute issues during the leave.

Additionally, the program expects residents to inform the clinic nurses (either in person or by posting a note in their clinic box or both) of their absence and who is covering their panel during the absence. In terms of clinic cancellation, the **minimum expectation** is that residents will have clinic no less than three times in four weeks.

MAKE-UP TIME:

If an extended leave results in a resident missing more than 25% of a given rotation, the expectation is that the resident will make up that time out of their own elective or vacation time. In the event that a resident has no unused elective or vacation time, the make-up time will be added to the end of their residency training.

Extended Leave Checklist

Date absence begins:_____ Date absence ends:_____
Total number of weeks:_____
Paid: _____
Vacation: _____
Unpaid: _____

Clinic Assignment:_____
Preceptor:_____

- **Clinic Preceptor notified of absence:**
  Signature:
  _____

- **Lisa Ingram notified of absence**
  Signature:
  _____

- **Number of clinics during the absence:_____**

Rotation Assignment During Absence:_____

Time to be made up: _____weeks

To be made up in: Elective time in _____ 20__

At end of residency

ACADEMIC LEAVE POLICY

FORMS
When routine time off is requested, a three-part leave of absence form should be completed at least six weeks' prior and given to Jessica Norles, accompanied by a clinic cancellation form. Both forms are available in the file drawer in the residents' lounge or in Jessica Norles' office.

ACADEMIC LEAVE:
Time taken for academic leave must be judged by the Program Director to be academic in nature and relevant to the curriculum and content of the residency. **THE RESIDENT MUST ARRANGE NECESSARY COVERAGE PRIOR TO THE LEAVE PERIOD. USMLE STEP 3 should be scheduled in such a way to avoid need for coverage.**

INTERVIEW DAYS:
The Office of Medicine Education and the Chief Resident should be notified prior to all planned absences. If problems arise without proper notification and coverage, a vacation day will be charged.

Time taken in excess of 14 days of combined academic and interview leave will be regarded as vacation and will be subtracted from vacation time accordingly.

All attempts should be made to plan ahead, avoiding inpatient ward rotations during fellowship interview season (March/April).

Residents taking interview days **MUST PROVIDE COVERAGE** for the involved service PRIOR TO the stated leave. It is NOT APPROPRIATE to have someone simply "be aware." If you are the only resident on a service, you must obtain permission from your service attending. If permission is denied by the service attending, the interview must be scheduled on an alternate day. The chief residents can assist in identifying potential coverage for interview days. **For up to 6 total days (2 per rotation),** the chiefs will arrange coverage without the resident being obligated to pay back the time. The resident is expected to ask the chiefs for support in this **as soon as they are aware of the interview invitation** to maximize the lead time their peers will receive when they must alter their schedule. Beyond 6 days total (or 2 per rotation), the resident is responsible for arranging coverage, although the chiefs and program leadership will do their utmost to ensure residents can interview as invited.

CONTINUITY CLINIC:
The requirements for coverage of continuity clinic during vacation apply for academic leave as well. In addition, ideally interview days SHOULD NOT occur on scheduled primary care clinic days. If an UNAVOIDABLE conflict arises and less than six weeks' notice is not possible, the resident is responsible for rescheduling ALL CLINIC PATIENTS to an alternate ADDITIONAL clinic day. Residents MUST apply for academic leave and interview days in the Office of Medicine Education. Leave will be granted only with the approval of a Chief Resident and the Program Director.

The combined total of interview and academic leave MAY NOT exceed 14 days for the **total residency**. Time taken in excess of 14 days will be regarded as vacation, and subtracted from vacation time accordingly.

VACATION POLICY

Time away from the hospital is necessary for vacation, fellowship/employment interviewing and academic conferences. Prolonged periods of leave however, compromise the educational experience of the resident taking leave, and burden the remaining residents and services. This policy is an attempt to create a balance between necessary leave and educational goals, requirements for board certification, service responsibilities, and patient care.

On any given clinical rotation the total amount of leave taken (vacation + academic leave + interview days) may not exceed 25% of the entire days of that rotation. If >25% of a clinical rotation is missed because of leave time, that clinical rotation must be repeated prior to graduation from the program.

VACATION:

G1 Residents:	Two weeks paid vacation + unpaid vacation last week in June
G2/3/4/5 Residents:	Three weeks paid vacation

Back-to-back vacations affecting two consecutive rotations may be approved only under exceptional circumstances, pending review by a Chief Resident and the Program Director. Two weeks vacation from a single rotation would (in most cases) exceed 25% of the time devoted to that rotation, and therefore is not allowed. (Except on non-required rotations, e.g. Electives.)
Requests for vacation must be made IN WRITING to the Office of Medicine Education at least SIX WEEKS in advance of the proposed leave. Conflicts among requests will be resolved on a first-come first-served basis.
Vacation requests must be approved by the Office of Medicine Education as well as the head of the department or subspecialty from which the vacation is being taken.

Continuity Clinic:
The six week vacation notice is necessary for the cancellation of the resident continuity clinic. A vacation request with fewer than six weeks notice needs special approval from the General Medicine Division Director, the Clinic Manager, and the Program Director. With less than six weeks notice, *if approved*, a resident will need to reschedule rather than cancel the affected clinic session.
During any vacation, the resident must leave a note on their clinic in-box notifying staff of their absence. They must also designate another resident or faculty to respond to patient care issues in their absence.

G1 Year:
Vacations cannot be taken from an inpatient ward rotation. However, Non-Medicine G1 residents are allowed to take one-week vacation from any inpatient medicine service.

G2-5 Years:
There will be no “carry over” of vacation time from one academic year to the next. One week of vacation should be taken from the first six months of the academic year, and one week of vacation should be taken from the second six months of the academic year. Vacation should be taken in one-week blocks. A Chief Resident and the Program Director will review special circumstances in consideration of requests for two consecutive vacation weeks.
G2/3 residents should schedule one vacation week from their elective period. No vacation may be taken from inpatient medicine services. On consult months when only one G2/3 resident is scheduled, vacations are not allowed unless a fellow is available (or a Family Practice resident is on the service as an elective) to cover the requested vacation time.

MEDICINE CLINIC POLICIES

MEDICINE CLINIC POLICIES

BACKGROUND:
Recognizing the challenges inherent in managing a busy continuity clinic practice while simultaneously caring for hospitalized patients, residents are not scheduled for continuity clinics during their call rotations. While they are on consult or ambulatory rotations (including the emergency department), they will have an AM and PM clinic once per week to provide patient care continuity. To accommodate acute patient care needs when their resident primary care physician (PCP) is on a ward month, each resident will part of a clinic treatment team.

Emergency Medicine-Internal Medicine (EM-IM) residents will be part of the Green Firm. During the Medicine portion of their training, EM-IM residents will have one clinic session per week on a designated afternoon, except that clinic will be cancelled with on-call or post-call. During the EM portion of their training, EM-IM residents will not have clinic as agreed upon for scheduling purposes but will be expected to be responsive to clinic needs.

Policy: Clinic Responsibilities

While residents will not have scheduled continuity clinic sessions during their ward months, **they are expected to continue managing their patient's medical issues (telephone calls, paperwork, in-box on EPIC),** while they are on the wards. PCPs are expected to schedule routine follow-up to occur during rotations when they will be in clinic, and they are also encouraged to set up acute care visits with patients who need their care, as their schedule allows. The practice partner is expected to see patients needing care who cannot be seen by their PCP.

PROCEDURES:
1. There will be no scheduled continuity clinics for residents during inpatient medicine blocks.
2. There will be one full day of continuity clinic per week for residents during their ambulatory and consult rotations.
3. Whenever possible, PCPs should schedule routine follow-up appointments with themselves for their primary patients (either prior to returning to upcoming ward months or after returning to continuity clinic).
4. **All residents will continue to manage their own EPIC in-box during ward and consult/ambulatory rotations**.
5. During ward months, residents are encouraged to schedule acute care visits as their schedule allows, if a clinical issue arises with one of their primary patients with which they wish to deal directly.
6. If a patient needs to be seen and the PCP is unable to accommodate a visit during a ward month, the firm nurse will schedule the patient into the next available slot in the Medicine Clinic.

Policy: Documentation

It is HCMC policy that providers shall complete the encounter by the end of the next business day. 'Best practice' is to complete the note by the end of the clinic day. Timeliness of chart completion will be monitored periodically by clinic staff and reported to the Firm Director. Records management will be part of your clinic performance evaluation.

Policy: Unacceptable Abbreviations

MEDICAL EXECUTIVE COMMITTEE ACTION:
"Independent Practitioners (members of the medical staff and residents/fellows) using unsafe abbreviations in orders. Nurses and HUCs will be asked to be the guardians of this process. They will call the Licensed Independent Practitioner who writes an unsafe abbreviation on the order form and ask

them to return to the unit and re-write the order in a safe manner. Licensed Independent Practitioners will be expected to return to the unit immediately when called, when it does not compromise patient care, to correct their unsafe order. Licensed Independent Practitioners who continue to write unsafe orders after three calls will be required to meet with the Medical Director and appropriate Department Chief to explain why their unsafe prescribing behavior persists."

Unsafe Abbreviations (do not use even in the electronic health record)

- U for units
- IU for international units
- ug for microgram
- A.S., A.D., A.U.O.S., O.D., O.U.
- Q.D., Q.O.D.
- Trailing 0 (1 not 1.0)
- Lack of leading 0 (0.1 not .1)
- MS, MS04, MgSO4
- Chemo abbreviations (ASA-C, 5FU, MTX)

Policy: Planned and Unplanned Resident Clinic Absences

It is expected that residents will make every effort to be in clinic at the assigned date and time. Any deviation from that expectation reduces patients' access to clinic and increases their frustration as well as clerical and nursing time. In addition, clinic cancellations increase the likelihood of various errors in follow-up scheduling, review of important lab and x-ray results, etc. Cancellation of clinic reduces the availability of residents to their patients and has an adverse impact on continuity and education.

It is the resident's responsibility to be aware of clinic scheduling.

PROCEDURE

1. A resident's clinic may be canceled or changed with at least six weeks' notice. Longer lead times to schedule changes are desirable.

2. Timely requests for changes in clinic will be made in writing to the practice manager. Clerical staff will not alter schedules, except by direction of the clinic manager or clinic/firm medical director.

3. Requests for clinic cancellations or changes with less than six weeks' notice will be presented to the appropriate firm director and/or practice manager. In the event a scheduling change is permitted, arrangements for coverage will be negotiated between the resident staff and the firm director. The practice manager will then be contacted for implementation of changes.

4. For illnesses or personal emergencies, the patient list for that day will be reviewed by the resident (if present), the chief medical resident, and/or the staff for the clinic. Patients needing to be seen or who cannot be reached and present themselves to the clinic will be seen by those present within the firm, either staff/resident/nurse practitioner or nurse in the firm. Those patients who may be rescheduled will be rescheduled as space allows or into a "prn" clinic agreed upon by the resident. Patients contacted who feel they need to be seen that day will be seen in the firm. Scheduled firm patients will not be sent to the Medicine Walk-In Clinic or the Emergency Department.

5. If the resident has asked someone else to cover his/her clinic, notification of the coverage will be made in writing to the Firm Director and to the firm clerk. The covering resident physician will not cancel or alter his/her own personal clinic for the purpose of providing coverage.

RESIDENT RESEARCH AND QUALITY IMPROVEMENT

EXPECTATIONS FOR RESIDENT RESEARCH

Consistent with ACGME requirements, each resident is expected to complete a scholarly project over the course of their training. Each resident presents their work at a poster session during the fourth quarter of the PGY3 year, where two winners are selected to present at medicine noon conference.

Examples of work that meet this requirement include but are not limited to independent research projects (surveys, chart reviews), literature reviews, and data analysis of existing information.

Some residents choose to use their elective time to pursue research projects. Due to criteria for Medicare reimbursement, the elective work needs to include clinical research and be clearly linked to the patient care experiences of the resident.

The program recommends that early in the PGY2 year, if not before, residents meet with the program director, one of the associate program directors, and/or the chief residents to receive guidance in developing a plan for their scholarly project.

Residents are encouraged to link with faculty mentors to identify and discuss areas/topics of research.

Funding for research should be coordinated with faculty mentors.

Financial support of up to $1500 is available for posters/oral presentations/etc, that are accepted for presentation at regional and national meetings. Please meet with Michelle Herbers immediately upon acceptance of presentations for all regional and national meetings to begin necessary paperwork. Receipts must be received within 50 days of travel to receive reimbursement. Please notify Michelle Herbers of all presentations and publications (date, location, and title) so they may be acknowledged in the IM Newsletter and the Department of Medicine Annual Report.

EXPECTATIONS FOR RESIDENT QI