Internal Medicine

PROGRAM HANDBOOK AND POLICY MANUAL

2017-2018
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### Faculty Listing and Clinical/Research Interests

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Faculty Listing and Clinical/Research Interests

Faculty Clinical and Research Interests:

Anderson – Clinical interests: physical diagnosis, bedside teaching. Research interest: faculty development in education

Chacko – Clinical interests: medical disease in pregnancy, preventive medicine, primary care. Research interests: graduate medical education (content, structure, design, and evaluation).

Davis – Clinical interests: general rheumatology. Research interests - health services research and adverse drug events in rheumatology using observational data.

Graham – Clinical Interests: pulmonary hypertension, hereditary hemorrhagic telangiectasia, pulmonary medicine and critical care medicine
Research Interests: inflammatory pulmonary vascular disease


Tad-y - Clinical interest: hospitalist medicine. Research interests: hospitalist training curriculum development and program evaluation, quality Improvement in medical education, learner assessment of internal medicine residents, program evaluation of internal medicine residency programs.

Gutierrez-Hartmann – Clinical interests: endocrine disorders, focusing on pituitary tumors and thyroid cancer. Research interests: role of ETS transcription factors in epithelial cell development and tumorigenesis, with a focus on pituitary mammary and GI model systems.

Program Curriculum

- Overall Educational Program Goals

The primary goal of the residency training program in Internal Medicine is to provide our residents with a three year, comprehensive graduate medical education experience
in a learning environment which offers the knowledge, skills and professionalism required to develop into a proficient general internist.

Internal medicine residents are assigned responsibilities that are commensurate with their level of training, and receive appropriate supervision from upper level residents, fellows, and faculty attending physicians in all aspects of patient care.

Over the course of training, residents will obtain competency in each of the six areas listed below as defined by the ACGME:

**Patient Care and Procedural Skills**
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 demonstrate the ability to manage patients:
1). (a) in a variety of roles within a health system with progressive responsibility to include serving as the direct provider, the leader or member of a multi-disciplinary team of providers, a consultant to other physicians, and a teacher to the patient and other physicians; (Outcome)
1). (b) in the prevention, counseling, detection, and diagnosis and treatment of gender-specific diseases; (Outcome)
1). (c) in a variety of health care settings to include the inpatient ward, the critical care units, the emergency setting and the ambulatory setting; (Outcome)
1). (d) across the spectrum of clinical disorders seen in the practice of general internal medicine including the subspecialties of internal medicine and non-internal medicine specialties in both inpatient and ambulatory settings; (Outcome)
1). (e) using clinical skills of interviewing and physical examination; and, (Outcome)
1). (f) by caring for a sufficient number of undifferentiated acutely and severely ill patients. (Outcome)

2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (Outcome)
2). (a) are expected to demonstrate the ability to manage patients:
2). (a). (i) using the laboratory and imaging techniques appropriately; and, (Outcome)
2). (a). (ii) by demonstrating competence in the performance of procedures mandated by the ABIM. (Outcome)
2). (b) must treat their patient’s conditions with practices that are safe, scientifically based, effective, efficient, timely, and cost effective. (Outcome)

**Medical Knowledge**
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents are expected to demonstrate a level of expertise in the knowledge of those areas appropriate for an internal medicine specialist, specifically:
1). (a) knowledge of the broad spectrum of clinical disorders seen in the practice of general internal medicine; and, (Outcome)
1). (b) knowledge of the core content of general internal medicine which includes the internal medicine subspecialties, non-internal medicine specialties, and relevant non-clinical topics at a level sufficient to practice internal medicine. (Outcome)
2) are expected to demonstrate sufficient knowledge to
2). (a) evaluate patients with an undiagnosed and undifferentiated presentation; (Outcome)
2). (b) treat medical conditions commonly managed by internists; (Outcome)
2). (c) provide basic preventive care; (Outcome)
2). (d) interpret basic clinical tests and images; (Outcome)
2). (e) recognize and provide initial management of emergency medical problems; (Outcome)
2). (f) use common pharmacotherapy; and, (Outcome)
2). (g) appropriately use and perform diagnostic and therapeutic procedures. (Outcome)

**Practice-based Learning and Improvement**
Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)
Residents are expected to develop skills and habits to be able to meet the following goals:
1) identify strengths, deficiencies, and limits in one’s knowledge and expertise; (Outcome)
2) set learning and improvement goals; (Outcome)
3) identify and perform appropriate learning activities; (Outcome)
4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)
5) incorporate formative evaluation feedback into daily practice; (Outcome)
6) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems; (Outcome)
7) use information technology to optimize learning; and, (Outcome)
8) participate in the education of patients, families, students, residents and other health professionals. (Outcome)

**Interpersonal and Communication Skills**
Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)
Residents are expected to:
1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)
2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)
3) work effectively as a member or leader of a health care team or other professional group; (Outcome)
4) act in a consultative role to other physicians and health professionals; and, (Outcome)
5) maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

**Professionalism**
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)
Residents are expected to demonstrate:
1) compassion, integrity, and respect for others; (Outcome)
2) responsiveness to patient needs that supersedes self-interest; (Outcome)
3) respect for patient privacy and autonomy; (Outcome)
4) accountability to patients, society and the profession; and, (Outcome)
5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

**Systems-based Practice**
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)
Residents are expected to:
1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)
2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)
3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)
4) advocate for quality patient care and optimal patient care systems; (Outcome)
5) work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)
6) participate in identifying system errors and implementing potential systems solutions. (Outcome)
7) work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients including the transition of care between settings; and, (Outcome)
8) recognize and function effectively in high-quality care systems.

- **ACGME Competency-Based Goals and Objectives for Each Assignment at Each Educational Level**

Our program uses the Internal medicine milestones, which relate to the above competencies, as a guide for determining progression through residency, and eventually, to certify graduates as ready for unsupervised practice. Our evaluation system is aligned with these 22 milestones and their sub-competencies. The internal medicine milestones can be found here: [Internal Medicine Milestones](#)

While there is no national standard for what is expected at each level of training, we have some basic expectations by year of training which can serve as a general guide for our residents listed in the next section.

**ACGME CORE COMPETENCIES- Expectations for performance by PGY level**

- **PATIENT CARE:** Residents are expected to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.

**PGY I:**
1) Performance of comprehensive history and physical examination
2) Synthesis of data into problem list and formulation of diagnostic plan with some supervision
3) Daily patient progress notes and close follow up of diagnostic tests/interventions
4) Daily communication with supervising attending physician
5) Effective communication skills accompanied by respectful and professional behavior in all interactions with patients and families

**PGY 2 and 3:**
1) Fulfillment of all the expectations of a PGY 1 as listed above
2) Formulation of independent diagnostic and therapeutic plans with the supervision of supervising attending physician
3) Coordination of patient care among all members of the health care team
4) Counseling and education of patients and their families
5) Development of competence in performing the core procedural skills essential to the practice of medicine

- **MEDICAL KNOWLEDGE:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and social-behavioral sciences, and the application of this knowledge to patient care

**PGY 1:**

1) Basic knowledge of pathophysiology, pharmacology, and clinical disease states
2) Demonstration of an analytic approach to clinical situations
3) Self-directed learning and reading of pertinent medical literature
4) Participation in organized educational activities that are designed to develop/expand medical knowledge base and to teach analytic thinking and problem solving:
   a. Attending rounds
   b. M&M and Outcomes Conferences
   c. Morning report
   d. Ambulatory clinic teaching conferences

**PGY 2 and 3:**

1) Fulfillment of all the requirements for PGY 1
2) Development of deeper understanding of disease states and their management
3) Development of skills in the reading and interpretation of the medical literature with application to patient care

- **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.

**PGY 1:**

1) Demonstration of a willingness to learn from errors
2) Participation at morbidity and mortality conferences
3) Participation in performance improvement activities – e.g. periodic ambulatory chart review of health maintenance practices
4) Utilization of available medical data bases, evidence based medicine resources to support clinical decision making
5) Education of students and other health care professionals
6) Participation in monthly journal club

PGY 2 and 3:

1) Fulfillment of all the requirements for PGY 1
2) Application of knowledge of study designs and statistical methods to the appraisal of clinical studies
   a. These skills are emphasized in OBMT rotations, journal club, ambulatory clinics
3) Development of competence in bedside teaching
4) Facilitate learning of students, junior residents and other health care professionals
5) Participation in monthly journal club

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

PGY 1, 2 and 3:

1) Development of strong language and documentation skills
   a. Succinct and comprehensive case presentations, progress notes
   b. Comprehensive computer based sign out of patient care issues
2) Efficient but comprehensive information exchange with colleagues, health care professionals, patients and their families
3) Development of effective listening skills
4) Establishment of a therapeutic and ethically sound relationship with patients and their families
5) Development of effective negotiation and leadership skills that assist in conflict avoidance, resolution (PGY 2 and 3 level)

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

PGY 1, 2 and 3:

1) Demonstration of respect, compassion and integrity in all interactions with patients, colleagues and other health professionals
2) Maintenance of a professional appearance
3) Commitment to ethical principles pertaining to confidentiality of patient information, informed consent
   a. Compliance with all HIPAA regulations (training provided at orientation)
4) Commitment to professional responsibility in the completion of all medical records in a timely fashion
5) Demonstration of a sensitivity to cultural differences, preferences
6) Development of skills in conflict resolution

- **SYSTEMS-BASED PRACTICE**

**PGY 1, 2, and 3:** 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.

1) Development of a basic functional knowledge of different types of medical delivery systems to which they are exposed during training
   a. University, county, and private hospital settings
   b. Exposure to basics of third party insurers
2) Collaborative efforts with ancillary team members (case management/social workers, utilization review) to provide high quality cost effective health care
3) Advocacy for patients in a health care system of limited resources

- **Didactics and Conferences**

The program provides protected time for residents to attend didactics on ambulatory block and/or clinic weeks for four hours on Wednesday mornings. Topics will be in accordance with the ACGME requirements for Internal Medicine Residencies which state that the core curriculum be “based upon the core knowledge content of internal medicine.” This protected curricular time hosts the Pathways and Tracks curricula as well as medical content learning. This core curricular content is delivered through a combination of in-person lectures and asynchronous online learning through Scientific American Medicine.

Conferences include Wednesday morning sessions on ambulatory blocks, hospital based conferences, continuity clinic conferences, subspecialty conferences during inpatient and elective rotations, as well as a monthly journal club, clinical pathologic conference, and morbidity and mortality conference. Attendance at these conferences is considered a priority for all house staff. Attendance at Wednesday sessions is mandatory for all residents unless on vacation. All residents are expected to complete the assigned Hopkins online modules for each year. These can be accessed online (below). In addition, the interns will receive a professionalism curriculum as well as a dedicated QI lecture series at their clinic sites.

Completion of on-line modules is available at [www.hopkinsilc.org](http://www.hopkinsilc.org) and review of conference material is available within MedHub under the conference tab.

- **Research and Scholarly Activities/Requirements**
Required for R2s and R3s. The following submissions will be considered acceptable options for completion of a scholarly activity (SA). Please note, the work involved in the activity must have been performed during the academic year for which you are submitting the SA. Ongoing research projects may be carried over from an earlier year provided there was still significant resident involvement in the project during the current academic year.

1. Abstract or poster submitted to local or national meeting (acceptance not required)
2. Manuscript of project or review of the literature (final draft form permissible, acceptance not required, if not yet submitted elsewhere mentor should approve)
3. Clinical protocol written by resident (final draft form permissible, actual opening of protocol not required, if not yet opened or submitted to agency, mentor should approve)
4. Research in progress report – an abstract that includes what was planned, what got done, what that showed, what is remaining to be done and a timeline as to when that is expected to be completed, or if the data were negative/uninformative, include a “pitfalls encountered and other directions or next steps” paragraph (mentor approved)
5. A case series or clinical vignette of an interesting case with brief review of the literature
6. A curriculum developed by the resident with a faculty mentor (institution of curriculum not required, must be approved by mentor for submission)
7. A quality improvement plan developed by the resident with a faculty mentor (implementation of plan not required, submission must be approved by mentor)

Other options may be permissible, but require approval by APD Lisa Davis (Lisa.Davis@ucdenver.edu) prior to submission. Your scholarly activity is to be uploaded to your learning portfolio in MedHub using the appropriate category, i.e. publication-abstract, presentation-national/regional, etc. In the notes section please add 17-18 Scholarly Activity.

- Electives
  Our program offers electives in all Internal medicine subspecialty disciplines. In addition, we have a multitude of non-traditional electives that residents can participate in – the full list is available to our residents on the website. 17-18 Resident Coursebook
Program Manual Statement

The training program complies with Accreditation Council for Graduate Medical Education (ACGME) and CUSOM Graduate Medical Education (GME) policies, procedures and processes that are available on the GME website. In addition, direct access is available by clicking the hyperlinks below. The program reviews all GME and program policies, procedures and processes at least annually with residents/fellows.

GME Policies

Additional Pay for Additional Work Policy
Concern/Complaint Policy
Disciplinary Action Policy
Duty Hours Policy
Eligibility and Selection Policy
Evaluation and Promotion Policy
Grievance Policy
International Residency Rotations Policy
Leave Policy
Medical Records Policy
Moonlighting Policy
Non-Compete Policy
Physician Impairment Policy
Prescriptions: Residents Writing for Staff, Family & Friends Policy
Professionalism Policy
Quality Improvement and Patient Safety Policy
Supervision Policy
Transitions of Care (Structured Patient Hand-off) Policy
Policy on USMLE (and COMLEX) Examinations
Work Environment Policy

Key University of Colorado Policies

Sexual Harassment Policy
Disability Accommodation Policy
HIPAA Compliance
Medical Student Learning Objectives

Adult Ambulatory Care (AAC) Learning Goals

1. Develop the knowledge attitude and skills appropriate to care for adults who present with symptoms or problems commonly seen in the community primary care setting.
2. Advance ability to communicate effectively with interprofessional colleagues including oral presentation of an adult outpatient encounter.
3. Form clinical questions and retrieve high quality evidence to advance patient care in the care of the outpatient adult.
4. Develop an appreciation of the value of the patient centered medical home and of team based care in chronic disease management in both primary care and subspecialty settings.
5. Develop knowledge skills and attitudes necessary to critically appraise the value of screening tests within a population and identify recommended preventive services and health promotion opportunities for different groups of patients at risk.
6. Develop professional attributes and lifelong learning skills.

Learning Objectives

1. Gather a comprehensive and focused history on adult patients in the outpatient setting.
2. Perform comprehensive and problem-focused physical examinations on adult patients in the outpatient setting.
3. Develop a prioritized differential diagnosis, select a working diagnosis, and develop an initial management plan following an outpatient encounter of an adult patient presenting with common clinical complaints including cough, fatigue, headache, low back pain, oral lesions, skin lesions, weight loss, and failure to thrive, sprains, strains, upper respiratory infections, urinary tract infections, and skin infections.
4. Perform appropriate diagnostic and screening tests, and initial management plan for chronic conditions commonly seen in the adult patient in the outpatient setting including allergies, asthma, depression, anxiety, diabetes, dyslipidemia, obesity, hypertension, end of life care, and domestic abuse.
5. Provide an oral presentation and written summary of an adult outpatient encounter that appropriately communicates the data acquired and the clinical reasoning that supports the differential diagnosis.
6. Communicate effectively with colleagues including physicians, nurses, medical assistants and other health care team members.

Hospitalized Adult Clerkship (HAC) Goals and Objectives

Students going through the hospitalized adult care clerkship are expected to be able to perform a history and physical exam, interpret testing, and participate in formulation of a treatment plan and differential for the following conditions:

- Anemia, Coronary Artery Disease, Cancer (any type), Chest Pain, Congestive Heart Failure, COPD or Asthma, PE and/or DVT, Dyspnea, Edema, GI Bleed, Liver Disease, Electrolyte Disturbance, Renal Failure, HIV Infection (Acute or Chronic), Nosocomial Infection, Pneumonia

Students are expected to be able to interpret the following clinical tests:
- ABG, BMP, ECG, Chest X-Ray, Cardiac Enzymes

Students also have the following objectives they should be able to complete by the end of the 8 week rotation:
- Complete written and oral communications that are organized, accurate, complete, concise, and incorporate prioritization and analysis of medical issues
- Discuss advanced directives and DNAR orders with patients and families
- Deliver difficult news including information regarding diagnosis and prognosis
- Demonstrate collaborative decision making
- Obtain a medical consultation from and communicate with subspecialty colleagues
- Perform peri-discharge education for a patient
- Demonstrate a commitment to carrying out professional responsibilities in a timely and efficient manner
- Interact respectfully with ALL members of the health care team
- Demonstrate sensitivity to a diverse patient population and provide culturally competent care
- Develop skills in team-based care (incorporating PT, OT, SLP, SW, CM, etc.)
- Understand some of the costs of an inpatient hospitalization
- Understand the resources available to patients upon discharge from the hospital
- Understand the common pitfalls associated with transitions in medical care from one setting to another

Additional Pay for Additional Work Policy

Additional Pay for Additional Work Policy

In addition to complying with the GME Additional Pay for Additional Work Policy.
the Internal Medicine program's policies and procedures are:

PGY 3 residents are permitted to work for additional pay while on pre-approved electives or during their +1 week. Additional shifts cannot interfere with duty hour compliance. PGY 2 residents can be invited to work additional shifts in the latter part of the academic year contingent upon staffing needs and approval by the program director.

Concern/Complaint Policy

In addition to complying with the GME Concern/Complaint Policy, the Internal Medicine program’s policies and procedures are:

The following options and resources are available and communicated to residents, fellows, and faculty annually:

**Step One:** Discuss the concern or complaint to the program’s Chief Resident, Service Director, Associate Program Director and/or Program Director, or Program Administrator as appropriate.

**Step Two:** If the concern or complaint involves the Program Director and/or cannot be addressed in option one, residents and fellows have the option of discussing issues with the section heads, division chiefs, and department chairs as appropriate.

**Step Three:** If residents are not able to resolve their concerns or complaints within the program, they may contact the GME Designated Institutional Official (DIO) via one of the following:

- Confidential email - gme@ucdenver.edu
- Anonymous Reporting Form

**Other Resources for Concerns and Complaints:**

1. Professionalism First (Ethics Point) is an anonymous reporting mechanism for residents and fellows to document exemplary professional behavior and identify professional lapses of either faculty, or other residents and fellows.
2. Housestaff Association: 303-724-3039
Duty Hours Policy

The Internal Medicine program complies with the ACGME Common and specialty-specific Program Requirements. In addition to complying with GME Clinical and Education Work Hours Policy, the Internal Medicine program’s policies and procedures are:

1. During emergency medicine assignments, duty is not to exceed 12 hours at a time.

Program Specific Duty Hour Monitoring Process

The program monitors and reports resident duty hours through monthly surveys sent out by GME. All residents and fellows are required to log work hours monthly via the survey system. The Program Director completes a monthly review of resident work hours and proactively adjusts schedules if needed to comply with duty hour requirements. The Program Director or Associate Program Director also reviews duty hours with each resident at their semi-annual and quarterly reviews. The Program Director works promptly and proactively with hospital sites and service directors to address duty hour issues.

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 in the assigned institution.

a. In-house call must occur no more frequently than every third, averaged over a four-week period.
b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours for all PGY levels. Upper level residents may remain on duty for up to 4 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care (unless further limited by the relevant Program Requirements).
c. An individual resident may accept no new patients after 24 hours of continuous duty.

Alertness Management and Fatigue Mitigation

The Program Directors, supervising faculty and Chief Medical Residents will monitor for fatigue among residents. Program and Core Faculty as well as residents will receive a presentation about fatigue and warning signs that it fatigue could be present and/or impairing work. The program will abide by and enforce the duty hours (see either ACGME rules or duty hours policy) such that there is sufficient time to rest in between shifts and after call duties. Backup supervision is available at all times for residents who feel they are impaired by fatigue. An excellent jeopardy system is in place. Furthermore, cab vouchers to get home are available at all times should trainees not feel safe to drive
themselves home. [Cab Voucher]. At no point should a housestaff member perform procedures or duties or drive while they knowingly feel overtired or impaired.

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**Eligibility and Selection Policy**

In addition to complying with GME [Eligibility and Selection Policy](#), the Internal Medicine program's policies and procedures are:

- ✔ We will accept only applications submitted through ERAS. If you are an international medical graduate, you must apply to our program through an ECFMG office.

- ✔ We generally look for USMLE scores at or above the average of 221, and expect that the individual will pass the exams in their first attempt.

- ✔ We require clinical (one month) experience in a U.S. healthcare system. We do not count observerships or research as clinical experience.

- ✔ We require a chairman's letter and three letters of recommendation with application which is a total of 4 letters.

- ✔ You must have graduated from medical school within the last three (3) years (2013). We require International Medical Graduate's to be ECFMG (Educational Commission for Foreign Medical Graduates) certified at the time of your application or far enough along in the application process that you will receive certification no later than February 1 of the year in which you plan to match.

- ✔ Residents in our program must be a U.S. citizen, a lawful permanent resident, refugee, asylee, or possess the appropriate documentation to allow a resident to legally train at the University of Colorado Denver School of Medicine.

The University of Colorado is unable to offer observerships or externships to anyone who has already graduated from medical school.

Our deadline for completed applications for 2017 - 2018 is November 15, 2017.
Evaluation and Promotion Policy

Criteria for Promotion & Graduation

In addition to complying with the GME Evaluation and Promotion Policy, the Internal Medicine program’s policies and procedures are:

The performance criteria on which housestaff will be evaluated mirror the ACGME CORE COMPETENCIES - Expectations for performance by PGY level. More specifically, residents will be evaluated on each of the ACGME competencies via a number of methods including but not limited to:

- Direct Observation on all rotations using milestone-based criteria
- Global Assessment
- Multisource assessment (input from affiliate partners such as nurses, medical assistants, clerical and admin staff)
- Patient survey
- In-training exam
- Practice audit (continuity clinic)
- Journal Club and Peer Teaching presentation review
- Participation in morning report/hospital based conferences
- Participation in a QI project
- Timely completion of all dictations and assignments
- Completion of all GME modules and any program-specific modules assigned
- Self-evaluation

Every 6 months (approximate) each resident will meet with his/her assigned APD in the program to review all evaluations and progress to date. This will include a self-evaluation by the resident in advance of these meetings. The APD will then note any areas requiring attention with the resident, and the APD will also forward on a recommendation of promotion, promotion with focus areas, or non-promotion to the Clinical Competency Committee (CCC). The CCC will meet approximately every 6 months and will take a global look at all residents in the program – each committee member will be assigned a group of trainees that they have no formal connection with a secondary review. The CCC will then vote on each resident based on the categories above (promotion, promotion with focus areas, non-promotion). These categories will be forwarded to the PD who will then make a final decision on each trainee every 6 months. All decisions will be reported to the trainees and their APDs as well as the ACGME via the NAS.

As noted in the GME Evaluation and Promotion Policy, residents’ advancement to a position of higher responsibility will be made only on the basis of an evaluation of their readiness for advancement and is not automatic. This will be heavily determined by the CCC noted above as they make recommendations to the PD.
regarding advancement. Reappointment and promotion are contingent on mutual agreement, and an annual review of satisfactory or better performance. Residents may be reappointed for a period of not more than one (1) year.

All interns and second year residents are expected to take the ITE (in-training examination). Scores will be provided to the residents, and for those that score <30th percentile, an individual remediation plan to address deficiencies is developed and the expectation to take the ITE again in their third year of training is set. An expectation that all graduates of the program take the ABIM (American Board of Internal Medicine) exam the summer after graduation is set.

Advancement from R1 to R2

- Successfully completed R1 rotations. The Residency Education Committee (REC) and APD will be responsible for reviewing any unsatisfactory evaluations and for determination of any necessary remediation.
- Competent to supervise R1 residents and medical students per Department of Medicine faculty evaluation.
- Able to perform resident duties with limited independence per Department of Medicine faculty evaluation.
- Successfully performed all entry-level procedures, with documentation on file in the Department of Medicine Housestaff Office.
- Presentation at Intern’s Journal Club completed.
- Has demonstrated sufficient progress in the components of clinical competence that he/she is capable of functioning as a team leader. Specifically, the resident has the necessary skills in data gathering, medical knowledge, clinical insight, and critical thinking to assume a team leadership role. He/she is demonstrating elements of practice-based learning and system-based learning in clinical encounters. No professionalism issues have arisen (see below).
- Has met PGY1 expectations for core competencies as outlined below.

Advancement from R2 to R3

- Successfully completed R2 rotations. The REC and APD will be responsible for reviewing any unsatisfactory evaluations and for determination of any necessary remediation.
- Completion of additional required procedures with documentation on file in the Department of Medicine Housestaff Office.
- American College of Physicians (ACP) poster submission completed. If accepted, should present at the National ACP meeting.
- Competent to supervise R1 and R2 residents and medical students per Department of Medicine faculty evaluation. All evaluations must be satisfactory or higher.
- Seeks appropriate consultation when indicated.
- Able to perform resident duties with minimal supervision per Department of Medicine faculty evaluation. The resident is capable of making independent decisions based on previous clinical experiences.
- Has the ability to recognize and manage “new” clinical problems (scenarios not previously encountered) skillfully.
• Has met PGY2 expectations for core competencies as outlined below.

Completion of training

• Successfully completed R3 rotations. The REC and APD will be responsible for reviewing any unsatisfactory evaluations and for determination of any necessary remediation.
• Passed USMLE Step 3, if eligible to sit for exam.
• Scholarly work completed
• American College of Physicians (ACP) poster submission completed. If accepted, should present at the National ACP meeting.
• Prepare and present a peer teaching clinic conference if required, and an article review for journal club.
• Completion of online Hopkin’s modules as assigned.
• Able to perform unsupervised care in the practice of general internal medicine per Department of Medicine faculty evaluation by the end of third year.
• Successfully performed all required procedures, with documentation on file in the Department of Medicine Housestaff Office.
• Has sufficient medical knowledge base, problem-solving skills, and clinical judgment that enable him/her to provide satisfactory patient care.
• Has demonstrated practice-based learning and system-based learning in clinical encounters.
• No professionalism issues have been present (see below).
• Has met PGY3 expectations for core competencies as outlined below.

At every level of advancement and at the time of completion of training, the resident must demonstrate the following:

• Interpersonal and communication skills are satisfactory or superior, as documented by evaluators in inpatient and ambulatory settings. Works well with patients, fellow residents, faculty, consultants, ancillary staff and other members of the health care team in a manner that fosters mutual respect and facilitates the effective handling of patient care issues as demonstrated by satisfactory staff and faculty professional behavior evaluations. Any disciplinary action plans as a result of unprofessional behavior must have been successfully completed.
• Absence of impaired function due to mental or emotional illness, personality disorder, or substance abuse. Any disciplinary actions or treatment programs implemented per the Department of Medicine policies on impaired function must have been successfully completed and reinstatement approved by the Internal Medicine Program Director and the REC.
Clinical Competency Committee

The Internal Medicine Clinical Competency Committee (CCC), is appointed by the Program Director, meets semi-annually, and assesses and provides input to the Program Director regarding Resident performance to be incorporated into the review process.

CCC Membership:
- Dr. Melver Anderson (Interim Program Director)
- Dr. James Beck (Professor, Pulmonary Sciences)
- Dr. Kathryn Berman (Clinic Director, Westside)
- Dr. Andrew Berry (Chief Medical Resident)
- Dr. Emily Bowers (Chief Medical Resident)
- Dr. Suzanne Brandenburg (Vice Chair for Education)
- Dr. Karen Chacko (Associate Program Director)
- Dr. Michelle Cleeves (Assistant Professor, Medicine)
- Dr. Julia Clemons (Residency Mentor and Clinical Instructor, Medicine)
- Dr. Daniel Reirden (Med Peds Associate Program Director)
- Dr. Lisa Davis (Associate Program Director)
- Dr. Amira Del Pino-Jones (Assistant Professor, Medicine)
- Dr. Ravi Gopal (Clinic Director, VA)
- Dr. Emily Gottenborg (Instructor, Hospital Medicine Group)
- Dr. Brian Graham (Associate Program Director)
- Dr. Francis Hall (Chief Medical Resident)
- Dr. Michael Hanley (Professor, Pulmonary Sciences)
- Dr. Daniel Heppe (Associate Program Director)
- Dr. Matthew Hoegh (Clinical Instructor, Medicine)
- Dr. Elisabeth Ihler (Clinic Director, Uptown)
- Dr. Mark Kearns (Associate Program Director)
- Dr. Julie Knoeckel (Chief Medical Resident)
- Dr. Vishnu Kulasekaran (Clinic Director, Webb)
- Dr. Trevor Lane (Chief Medical Resident)
- Dr. Jonathan Manheim (Clinical Instructor, Medicine)
- Dr. Adrienne Mann (Clinical Instructor, Medicine)
- Dr. Tyler Miller (Clinical Instructor, Medicine)
- Dr. Edward Murphy (Clinic Director, Lowry)
- Dr. Susan Nikels (Clinic Director, Anschutz)
- Dr. Natalia Roldan (Clinical Instructor, Medicine)
- Dr. Yasmin Sacro (Residency Mentor and Clinical Instructor)
- Dr. Sarah Christensen (Clinic Director)
- Dr. Karen Shea (Assistant Professor, Geriatrics)
- Dr. Jennifer Stichman (Clinic Director, Webb)
- Dr. Kathleen Suddarth (Associate Program Director)
- Dr. Darlene Tad-y (Associate Program Director)
- Dr. Charles Tharp (Chief Medical Resident)
- Dr. Kinnear Theobald (Clinical Instructor)
- Dr. Julie Venci (Interim Med Peds Program Director)
- Dr. Kelly White (Residency Mentor and Associate Professor, Medicine)
Residents do not serve on the CCC.

CCC Responsibilities include, but are not limited to:

The committee assesses the Resident’s performance based on the Skills, Goals and Objectives of the overall program. Additional sources reviewed by the CCC include, but are not limited to:

- Multi-source evaluations (peers, staff, self, patient, students, faculty)
- End of Rotation Evaluations
- Procedural observations
- In-Training Exams
- Case Logs
- Conference attendance and participation
- Research and scholarly activity
- Quality Improvement and Patient Safety projects
- Compliance with duty hour requirements

At a minimum, the CCC performs the following functions:

1. Reviews all Resident evaluations semi-annually,
2. Prepares and ensures the reporting of Milestones evaluation of each Resident semi-annually to ACGME, and
3. Advises the Program Director regarding Resident progress, including promotion, remediation, and dismissal.

The CCC follows the GME Evaluation & Promotion Policy and makes recommendations to the Program Director on Resident progress, including promotion, remediation and dismissal. The CCC identifies Resident strengths and areas for improvement. The CCC ensures the reporting of Milestones to ACGME.

The Program Director meets with the Resident semi-annually to review the CCC report and design a learning plan for the Resident. Minutes for the CCC will be taken and kept on file.
Leave Policy

In addition to complying with the GME Leave Policy, the Internal Medicine program’s policies and procedures are:

Training must be extended to make up any absences exceeding one month per year of training. Vacation leave is essential and cannot be forfeited or postponed in any year of training and cannot be used to reduce the total required training period. Residents who take extended leave and will not complete their PGY3 year by August 31st will be ineligible to sit for the ABIM boards for that year.

The Internal Medicine Residency Program Office will work with residents to arrange time off for leave purposes. Residents are required to give at least 5 months’ notice for parental leave requirements.

Medical/Parental/Military/Family Leave*: A resident may request a maximum of twelve weeks of family leave. The first four weeks minus any vacation leave already used will be with full pay and benefits, and will include any remaining vacation leave for the contract period. The remainder of the twelve weeks will be without pay; however, benefits will be billed at the employee rate. If the period of leave bridges two consecutive contract periods, the amount of paid and unpaid leave will be allocated proportionately, including available vacation days.

*All requirements of the residents’ respective Board must be satisfied. Board requirements will take precedence over leave of absence policies, when applicable.

We have a strict (program) policy for any medical/parental/military/family leave. Anything over the one-month absence must be made up in the same year of training, thus extending the completion date.

Parental Rotation Option
With at least 5 months’ notice, residents may request a board review elective during the month their child is born. Residents will be eligible for this elective if they are on track to meet their ACGME and ABIM requirements (1/3 of training in the ambulatory setting and a maximum of 3 non-clinical months). Residents who participate in this elective will be required to complete MKSAP practice tests and turn them into the housestaff office on a pre-determined schedule.

Up to three days of jeopardy coverage are provided to those on inpatient rotations when their child is born.

Policy for Sick Leave
In addition to contacting your Chief Resident, Jennifer Weber and appropriate
rotation supervisors for episodes of acute illness, residents should contact the
program director as far in advance as possible to discuss any anticipated absences
due to personal or family health issues.

Jury Duty
If summoned while on an inpatient month, housestaff should ask for a
deferment of Jury Duty to a non-call month (in order to avoid inconveniencing
colleagues). The housestaff office requires a copy of each Jury Summons
and the paperwork issued by the Jury Commissioner for each day that you
actually serve. Please call the night before jury duty to see if you are required
to appear. If not required, please notify the CMR and your current rotation
supervisor as well as Jennifer Weber and plan to show up at your regularly
scheduled clinic the next morning.

Failure to produce the proper documentation will necessitate use of vacation time.

If a resident is summoned for a Grand Jury or other long trial, they should notify
Jennifer Weber in the Housestaff Office immediately, and if appropriate we will
write a letter requesting that he/she be excused.

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Moonlighting Policy

Moonlighting Policy

In addition to complying with the GME Moonlighting Policy, the Internal Medicine
program’s policies and procedures are:

R1  Moonlighting is prohibited at any time without exception.

R2  Moonlighting is prohibited while on ward rotations without exception.
    Moonlighting is strongly discouraged while on specialty rotations. Under
    unusual circumstances of financial need, permission to moonlight may be
    requested from the Program Director for approval by the Residency
    Committee.

R3  Moonlighting is prohibited while on ward and float rotations without
    exception. Any resident who decides to moonlight while on a specialty
    rotation should be aware that reports from his/her clinical supervisors that
    moonlighting is interfering with the resident’s clinical work will be viewed
    as significant evidence of irresponsible behavior. Residents who elect to
    moonlight should be especially careful when setting up their schedules to
    avoid potential conflicts; e.g., they must not moonlight while on call for some
    of the subspecialty divisions.

    Moonlighting can occur on OBMT as a last minute fill in and as long as you are
duty hour adherent. This must be approved by the OBMT Chief Resident.
Only two moonlighting shifts are allowed while on MKSAP study.

No resident is required to moonlight. All residents who moonlight must have a form on file with the Department of Medicine Housestaff Office. It is the resident’s responsibility to supply completed forms to the Department of Medicine Housestaff Office as well as the moonlighting venue. All moonlighting must be done in accordance with the ACGME duty hours so that these rules are not violated. Any resident who exceeds ACGME duty hour limits due to moonlighting will have their moonlighting privileges revoked for at least six (6) months. Moonlighting done at any affiliated hospitals (aka extra work for extra pay) will be monitored by the training program to be sure no work rules violations have occurred. Any houseofficer on a letter of focused review or probation will not be allowed to moonlight without exception, in accordance with the GME rules.

Professionalism Policy

All residents/fellows must also abide by the professionalism principles and guidelines as stated by the ACGME program requirements.

Monitoring Resident Professionalism

The program director and faculty monitor resident delinquency and professionalism by:

All evaluations are monitored for low or unacceptable professionalism marks. The program director meets at a minimum monthly with the Chief Medical residents who are the front-line sources of gathering any incident reports on rotations. Our confidential advisors are trained in when it is reasonable to break confidentiality as regards professionalism (in cases of safety issues) and they will report to Program Director as well.

Technical requirements relating to professionalism are monitored via semi-annual meetings as well as direct reports generated for some requirements such as dictation deficiencies, lack of recording duty hours, failure to complete assigned modules, lack of response to emails or requests from the program administration, etc.

Please refer to the GME Professionalism Committee Procedure for method of review of reports of exemplary professionalism or lapses in professionalism by residents.

The Internal Medicine Residency Program Policy of consequences for noncompliance with program requirements is as follows:
<table>
<thead>
<tr>
<th>Miss</th>
<th>Action Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; miss</td>
<td>CMR to speak with resident; email confirmation to the program office and Associate Program Director thereafter.</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; miss</td>
<td>Email or written notice with offer to speak to Chief Medical Resident and/or Associate Program Director.</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; miss</td>
<td>Email or written notice. Meet with Chief Medical Resident and Associate Program Director.</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; miss</td>
<td>Email or written notice. Meet with Chief Medical Resident and Associate Program Director. Resident advised they will be brought to Clinical Competency Committee for review for ACGME Milestone PROF-2 (“Accepts responsibility and follows through on tasks.”).</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt; miss</td>
<td>Email or written notice. Meet with Chief Medical Resident and Associate Program Director. Resident advised they will be brought to Clinical Competency Committee for review for Milestone PROF-2. Focused Review initiated for PROF-2 (not a permanent part of training file).</td>
</tr>
<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt; miss</td>
<td>Email or written notice. Meet with CMR and APD. Resident advised they will be brought to Clinical Competency Committee for review for Milestone PROF-2. Probation initiated for PROF-2 (permanent part of training file).</td>
</tr>
</tbody>
</table>

*Missed Deadlines accumulate throughout the course of residency; there is not a ‘reset’ between academic years.*

**Professionalism Education**

The program provides the following professionalism education to residents:

Residents are provided professionalism education via GME New Resident Orientation and modules, program didactic conferences and departmental grand rounds.

**Program Evaluation**

**Program Evaluation Committee**

The **Internal Medicine Program Evaluation Committee (PEC)** documents formal, systematic evaluation of the curriculum on an annual basis and is responsible for the Annual Program Evaluation (APE). The PEC follows the GME Evaluation & Promotion Policy.
PEC Membership:
- Dr. Melver Anderson (Interim Program Director)
- Dr. Karen Chacko (Associate Program Director)
- Dr. Lisa Davis (Associate Program Director)
- Dr. Brian Graham (Associate Program Director)
- Dr. Daniel Heppe (Associate Program Director)
- Dr. Christopher King (HAC Student Clerkship Director)
- Dr. Kathleen Suddarth (Associate Program Director)
- Dr. James Beck (Professor, Pulmonary Sciences)
- Dr. Kathryn Berman (Clinic Director, Westside)
- Dr. Suzanne Brandenburg (Vice Chair for Education)
- Dr. Michelle Cleeves (Assistant Professor, Medicine)
- Dr. Julia Clemons (Residency Mentor and Clinical Instructor, Medicine)
- Dr. Mark Kearns (Associate Program Director)
- Dr. Jonathan Manheim (Clinical Instructor, Medicine)
- Dr. Adrienne Mann (Clinical Instructor, Medicine)
- Dr. Yasmin Sacro (Residency Mentor and Clinical Instructor)
- Dr. Darlene Tad-y (Associate Program Director)
- Dr. Julie Venci (Interim Med Peds Program Director)
- Dr. Kelly White (Residency Mentor and Associate Professor, Medicine)
- Dr. Andrew Berry (PGY 4)
- Dr. Emily Bowers (PGY 4)
- Dr. Frank Hall (PGY 4)
- Dr. Trevor Lane (PGY 4)
- Dr. Charles Tharp (PGY 4)
- Dr. John Williams (PGY 4)
- Dr. Amy Yu (PGY 4)

PEC Responsibilities include, but are not limited to:
- Planning, developing, implementing, & evaluating educational activities of the program
- Reviewing & making recommendations for revision of competency-based curriculum goals & objectives
- Addressing areas of non-compliance with ACGME standards
- Reviewing the program annually using evaluations of faculty, residents, and others

At a minimum, the PEC monitors and tracks the following areas:
- Resident performance
- Faculty development
- Graduate performance, including performance of program graduates on the certification examination
- Program quality:
  - Resident & Faculty confidential, annual evaluation of the program
  - Use of these assessments of the program with other program evaluation results to improve the program
- Progress on the previous year’s action plan(s)
The PEC prepares an Action Plan (per GME Template) documenting initiatives to improve the program, as well as how the initiatives are monitored & measured. The Action Plan serves as the minutes for the PEC and should be reviewed by the teaching faculty.

Quality Improvement/Patient Safety Policy

Quality Improvement and Patient Safety Policy

In addition to complying with the GME Quality Improvement and Patient Safety Policy, the Internal Medicine program’s policies and procedures are:

- All interns will complete the IHI modules on QI/QS online – these will be tracked for completion. Interns are also responsible for the "QI deliverables" presented to them at curriculum sessions – these two forms are available online (ambulatory QI H+P and Initiative). Most residents will conduct their QI projects at their clinic sites under the supervision of ambulatory faculty. However, residents may end up doing a QI project in the inpatient settings (this is especially true for HTT track trainees) or be involved in more than one project in multiple settings.

- R1s and R2s are required to attend and fill out QI forms at a minimum of 2 M+M conferences at the University or VA each year – these must be uploaded into MedHub. For R3s, the requirement is for 1 per year. All three years are encouraged to attend every M+M held and participate whenever possible - the above are only the minimum requirements.

Supervision Policy

Supervision Policy

In addition to complying with the GME Supervision Policy, the Internal Medicine program’s policies and procedures are:

Program Supervision Policy

All program faculty members supervising residents must have a faculty or clinical faculty appointment in the School of Medicine or be specifically approved as supervisor by the Program Director. Faculty schedules will be structured to provide residents with continuous supervision and consultation.

Residents must be supervised by faculty members in a manner promoting progressively increasing responsibility for each resident according to their level of education, ability and experience. Residents will be provided information
addressing the method(s) to access a supervisor in a timely and efficient manner at all times while on duty.

**Supervision of At-Home Call:**
Residents may decide to check on clinic patient tasks while at home, but this is not required by the residency program. If they choose to do this, they are to have all work supervised and cannot act independently. They may enter orders to be authorized by attendings (pended) and may contact patients as they normally would during clinic (with documentation of all calls which are to be cc’d to attendings) knowing that attendings are immediately available by phone, providing indirect supervision with direct supervision available.

**Progressive Authority & Responsibility, Conditional Independence, Supervisory Role in Patient Care**

PGY-1 residents are supervised either directly or indirectly with direct supervision immediately available.

The program provides additional information addressing the type and level of supervision for each post-graduate year in the program that is consistent with ACGME program requirements and, specifically, for supervision of residents engaged in performing invasive procedures -see linked Housestaff Procedure Supervision document. [Procedure Supervision](#)

**Guidelines for When Residents Must Communicate with the Attending**

Any time a patient is transferred to a higher level of care or when end-of-life decisions are made, the supervising attending will be notified within 24 hours by the team. Supervising attendings should be explicit in directing residents when to notify them and if they differ from the 24 hour policy (cannot be longer than 24 hours).

**Clinical Responsibilities by PGY Levels for Supervision**

Please see detailed [Supervision Policy](#).
Transitions of Care Guidelines – Hand-off Process

Transitions of Care (Structured Patient Hand-off) Policy

In addition to complying with the GME Transitions of Care (Structured Patient Hand-off) Policy, the Internal Medicine program’s transition of care process that is used is I-PASS.

Program Policy for Transition of Care is as follows:

Minimal Handoff Requirements:

1. **Time/Place**
The location should minimize distractions/interruptions and allow access to needed resources (e.g., appropriate information systems). The handoff process **MUST** allow the receiving physician to ask questions; thus, verbal, face-to-face handoffs are required as well as written. The handoff process **MUST** be delayed in the setting of an unstable clinical situation allowing the active care provider to transition the patient to a safer level of care.

2. **Structure/Protocol**
Written information for trainees in a supervisory or consultative role must include sufficient information to understand and address active problems likely to arise during a brief period of temporary coverage, or to assume care without error or delay when care is transferred at a change of rotation or service. The general template for written sign out is the same at each site with slight variations based on the site-specific software. A training session is held during orientation to instruct the interns how to use the written sign out and keep it updated and the interns have the opportunity to practice verbal sign out using the written sign out.

3. **All patients for whom a resident or fellow is responsible must be included in the handoff.**

4. **Transitions of Service**
Except for transfers in emergency situations, a transfer note must be provided by the “sending” resident or fellow when a patient is transferred to a different level of care or to a different service. Acceptance of the transfer must be documented by the receiving service. Transition of service must additionally be made clear to the multidisciplinary staff caring for each transitioned patient. Residents/Fellows are accountable to additional requirements as specified in each institution’s Medical Staff Policies/Rules/Regulations.

   1. **End of Rotation Transition**
End of rotation handoffs will involve either written or verbal sign out between residents. On switch days when residents are changing services, the ‘warm handoff’ program will be used at all sites. This is a process whereby the outgoing resident/intern
and incoming team will be physically present together and see patients in-person together to facilitate patient care during team transfer days. Everyone is expected to be present for warm handoffs, and attendance will be monitored. The only excused absences from warm handoffs are for those who start a vacation week the day of transition. Additionally, the residency is currently studying an end of rotation handoff bundle in the ICU at University Hospital.

2. Evaluation

Each resident is expected to use the designated structured handoff process at each site for every patient. Specific evaluation forms called “safe and effective discharge” will be performed on interns during specified rotations at University Colorado Hospital. In the units, the handoff process will often be monitored directly by the fellow or attending on service, and on the inpatient wards the attending physicians will monitor the process frequently (especially early on in the year) as well as audit written sign outs.

Transitions of care are evaluated on monthly inpatient rotation

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**USMLE (and COMLEX) Examinations**

**Policy on USMLE (and COMLEX) Examinations**

In addition to complying with the GME Policy on USMLE (and COMLEX) Examinations, the Internal Medicine program’s policies and procedures are:

1. USMLE Step 3 must be completed in PGY1 year.

2. USMLE Step 3 examinations are to be scheduled during an elective rotation. If this is not feasible, with 4 months’ advanced notice, the exam can be scheduled during a +1 week. Once your exam has been scheduled, you must notify Nicole Canterbury at Nicole.Canterbury@ucdenver.edu and your rotation director of your scheduled dates. A copy of your USMLE score needs to be provided to Darla Schwab (Darla.Schwab@ucdenver.edu) in the Housestaff Office. Details for scheduling USMLE can be found on our website.

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**ACGME Specific Program Requirements**

The program will incorporate the current Accreditation Council for Graduate Medical Education program requirements within this Program Manual annually.

**ACGME Internal Medicine Program Requirements**