INTERNAL MEDICINE RESIDENCY

TRAINING PROGRAM MANUAL

2013-2014
## CONTACT INFORMATION

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Faculty Clinical and Research Interests:

Brandenburg – Clinical interests - women’s health, aging, and lifestyle modification to improve health. Research interest is medical education.

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, evaluation).

Glasheen – Clinical interest…perioperative and consultative medicine. Research interest…quality and safety

Klopper – Clinical and research interests include novel treatment strategies for poorly differentiated thyroid cancer and thyroid cancer survivorship

Mancini – Clinical interests include observation medicine, hospital flow, academic service design, and care transitions. Research interests are in transitions and hospital readmissions.

Adams – Clinical interest: primary care, HIV. Research interest: medical education, HIV

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.

Heist – Clinical interest - general primary care. Research interests - innovations in resident education and new models for resident evaluation.

Tad-Y - Clinical interests – 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
The University of Colorado SOM Internal Medicine residency Training Program complies with Accreditation Council for Graduate Medical Education (ACGME) and UCDSOM Graduate Medical Education (GME) policies, procedures and processes which are available on the GME website and manual. http://www.ucdenver.edu/academics/colleges/medicalschool/education/graduatemedicaleducation/GMEDocuments/Documents/GME%20Manual.pdf

In addition, direct access is available by clicking hyperlinks throughout this Program Manual. The program reviews all GME and program policies, procedures and processes at least annually with residents/fellows.

Program Curriculum

3A. and 3B. Competency-based educational goals by PGY level and ACGME core competencies

**GENERAL DESCRIPTION**

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:

a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

b. **Medical 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

c. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

d. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals

e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

f. **Systems-Based Practice**, as manifested by actions that 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

**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 I:
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

**3C. Didactics and Conferences**

The program provides protected time for residents to attend didactics on each ambulatory block (upper level residents) or clinic week (interns) for four hours each Wednesday morning. 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.”

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 housestaff. Attendance at Wednesday sessions is mandatory for all residents on an ambulatory block 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 which is new in academic year 2013-4 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 at [Blackboard](http://blackboard.cuonline.edu/webapps/portal/frameset.jsp)

**3D. 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. [http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/intmed/imrp/RESOURCES/Documents/Resident%20Course%20Book%202012-13.pdf](http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/intmed/imrp/RESOURCES/Documents/Resident%20Course%20Book%202012-13.pdf)

**Procedures Policy**

All residents will be instructed in the indications, contraindications, complications, limitations, and interpretation of findings as related to procedures. Appropriate supervision for all procedures is available 24-hours a day every day. All residents must develop competency in the interpretation of electrocardiograms.
All residents should develop competency in the interpretation of chest roentgenograms, spirometry, KOH/wet preps of vaginal smears, and other office-based lab procedures such as gram stains and urine microscopy.

In order to be eligible for Internal Medicine Boards, all residents must be compliant with the American Board of Internal Medicine (ABIM) guidelines and ACGME requirements for procedures which have been modified this year. The current requirements are:

**Competency is required in the following procedures:**

<table>
<thead>
<tr>
<th>Know, Understand and Explain</th>
<th>Perform Safely and Competently</th>
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<tr>
<td>Indications; Contraindications; Recognition &amp; Management of Complications; Pain Management; Sterile Techniques</td>
<td>Specimen Handling</td>
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<tr>
<td>Abdominal paracentesis</td>
<td>X</td>
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<tr>
<td>Advanced cardiac life support</td>
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<tr>
<td>Arterial line placement</td>
<td>X</td>
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<td>Arthrocentesis</td>
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<td>Central venous line placement</td>
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<td>Drawing venous blood</td>
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<td>Drawing arterial blood</td>
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<td>Electrocardiogram</td>
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<td>Incision and drainage of an abscess</td>
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<td>Lumbar puncture</td>
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<td>Nasogastric intubation</td>
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<td>Pap smear and endocervical culture</td>
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<td>Placing a peripheral venous line</td>
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<td>Pulmonary artery catheter placement</td>
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<td>Thoracentesis</td>
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We are committed to providing each resident with the opportunity to gain competency in each of the procedures and strongly encourage residents to log procedures meticulously in MedHub as credentialing organizations may ask for this data in the future before allowing individual graduates specific privileges.

Please note **these must be documented using the available on-line format through MedHub that the residency program provides in order to be considered accounted for.**
3E. Research/Scholarly Activity Guidelines

Introduction:
In accordance with ACGME Common Program Requirements, residents must “systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.” As such, “The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.”

The University of Colorado Denver School of Medicine (UCDSOM) Graduate Medical Education Committee (GMEC) requires each ACGME accredited residency and fellowship program develop policies to ensure all residents are involved in Quality Improvement/Patient Safety (QI/PS) activities.

Definition:
Quality Improvement/Patient Safety activities include but are not limited to the following:

- Individual Practice Assessment and Improvement Plan
  - Each resident identifies both a preventive measure and chronic disease measure in their continuity clinics
  - They conduct an audit of their practice to assess compliance with guidelines and outline a goals and plans for improvement
- Quality Improvement/Patient Safety Conferences (e.g., Morbidity and Mortality)
  - These conference will be facilitated by faculty members to allow for discussion of both cognitive errors and systems factors
  - All residents are required to attend
- Participation in institutional Quality Management Committees
- Participation in efforts to achieve Patient-Centered Medical Home (PCMH) designation in ambulatory clinics
  - Each resident will have the opportunity to work on QI projects with their continuity clinics to achieve required metrics for receiving PCMH designation
- Participation in relevant longitudinal QI projects with clinical partner (e.g. improvement of quality of transitions of care)
- Elective Quality Improvement rotations
- Scholarly activity resulting in implementation of initiatives to improve patient quality and safety of care

Policy:
Each residency and fellowship program must ensure each resident participates in Quality Improvement/Patient Safety activities. The level of participation will vary depending on the functional role of the resident or fellow in patient care and the QI/PS activities currently underway within the clinical setting and institution.

1. At a minimum, every training program must incorporate Quality Improvement/Patient Safety Conferences (a.k.a., Morbidity and Mortality) into its curriculum, including use of the prescribed Patient Safety/M&M/Occurrence Review Form if applicable to the institution.
2. At least annually, in conjunction with the Annual Program Evaluation, the Designated Institutional Official for GME will provide the GMEC with a report of QI/PS activities as they pertain to the residents and the teaching programs.
3. The DIO will address any concerns identified regarding insufficient QI/PS involvement.
All interns will attend the QI lecture series designed by Dr. Tad-Y and will be responsible for the “QI deliverables” reviewed during those sessions. 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.

4A. GME Disciplinary Policy

The University of Colorado SOM Internal Medicine Training Program complies with the GME Disciplinary Policy linked above.

4B. Grievance Policy

The University of Colorado SOM Internal Medicine Training Program complies with the GME Grievance Policy linked above. Grievances are limited to allegations of wrongful dismissal, wrongful suspension, wrongful nonrenewal or wrongful renewal without promotion of the annual Resident Training Agreement. Being placed on probation and immediate suspension from clinical responsibilities are not grievable. The decision to suspend from the program, dismiss, not renew or renew without promotion a resident is an academic responsibility and is the decision of the University of Colorado School of Medicine Graduate Medical Education programs.

Any houseofficer who is suspended, terminated, or whose housestaff training agreement is not renewed shall be informed of the decision in person or by certified mail.

Houseofficers who have been dismissed or terminated from the program have the right to invoke the grievance process within 10 days of notification if they believe the action is in error. A review committee will be assembled and will involve a representative from the University counsel. Once the hearing is over, a decision will be made within 30 days thereafter.

All issues relating to professionalism and/or substance abuse will be reported to the Colorado Physicians Health Program (CPHP) as required by Colorado Law.

We will report any issues to the Colorado Board of Medical Examiners (CBME) that we are required to by law. These can include any violations of the Colorado Medical Practice Act. (http://198.187.128.12/colorado/lпext.dll?f=templates&fn=fs-main.htm&2.0 relevant material under Colorado Statutes, Title 12, Article 36, Section 12-36-117)

In the event of an adverse annual evaluation, houseofficers have the opportunity to address any academic deficiencies or misconduct before a subcommittee of the local Residency Committee.

Program Concern/Complaint Policy

To ensure that residents and fellows are able to raise concerns and complaints in a confidential and protected manner in an environment which fosters open communication without fear of intimidation and retaliation, the University of Colorado SOM Internal Medicine Training Program complies with the GME Concern/Complaint Policy. The program specific concern/complaint policy is as follows:

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 Coordinator 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 on the GME website: [http://www.ucdenver.edu/academics/colleges/medicalschool/education/graduatemedicaleducation/concerns/Pages/form.aspx](http://www.ucdenver.edu/academics/colleges/medicalschool/education/graduatemedicaleducation/concerns/Pages/form.aspx)

**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. [http://www.ucdenver.edu/academics/colleges/medicalschool/facultyAffairs/ProfessionalismFirst/Pages/default.aspx](http://www.ucdenver.edu/academics/colleges/medicalschool/facultyAffairs/ProfessionalismFirst/Pages/default.aspx)


3. University of Colorado Ombuds Office: 303-724-2950 [http://www.ucdenver.edu/about/departments/OmbudsOffice/Pages/OmbudsOffice.aspx](http://www.ucdenver.edu/about/departments/OmbudsOffice/Pages/OmbudsOffice.aspx)

**4C. Duty Hours and On Call Policy**

**Policy**
The program policy on duty hours for residents follows the intent and language found in the Accreditation Council for Graduate Medical Education (ACGME) guidelines addressing this topic and is consistent with policy adopted by the Graduate Medical Education Committee linked above.

The program also complies with the duty hours process and the program specific monitoring process is outlined below.

**Duty Hours**
The program complies with all duty hour regulations as defined by the ACGME Internal Medicine RRC - [http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/140_internal_medicine_07012009.pdf](http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/140_internal_medicine_07012009.pdf)

a. Duty hours are defined as all clinical and academic activities related to the residency program, ie, patient care (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.

b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational and administrative activities.

d. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

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

Duty Hour Monitoring Process

The program monitors and reports resident duty hours through the GME Residency Management System MedHub. All residents and fellows are required to log work hours weekly in the MedHub 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 also reviews duty hours with each resident at their semi-annual and quarterly reviews. If a resident receives a duty hour violation, he/she will meet with the Program Director immediately to find out why the violation happened and create a plan of action to prevent future violations. 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 night, averaged over a four-week period.

b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours for PGY-2 and PGY-3, no more than 16 hours for PGY-1 level. 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.

4Cii. Alertness management and Fatigue Mitigation and Work Environment

The Program Directors, supervising faculty, and Chief Medical Residents will monitor for fatigue among residents. Faculty and residents will receive a presentation about fatigue and warning signs that it 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. At no point should a housestaff member perform procedures or duties or drive while they knowingly feel overtired or impaired.

The work environment at all rotations shall be in accordance with the University Hospital bylaws. Harassment of any type will not be tolerated – residents who feel they are being harassed should report to the Program Director or the Ombudsperson provided by the University. Issues about the
program can also be reported to the Housestaff Association. Any reports to the Ombudsperson or Housestaff Association are confidential and can be reported without fear of retaliation.

At no time will housestaff be expected to routinely perform phlebotomy. Coverage by the housestaff will be limited to those patients on the teaching service. No resident will do more than 6 weeks of night float in any given academic year. Access to food services will be available in all hospitals and call rooms will be provided in all hospitals. There will be a way to secure personal items at all facilities, and police or security personnel will be available to housestaff at all times.

4Ciii. Call policy/guidelines

Every resident is expected to take assigned call as set forth by schedules available on AMION and through the Chief Medical Residents. Pagers will be worn at all times during call and pages will be answered in a timely fashion. Failure to report for call is grounds for probation. Specific policies related to schedules are noted below.

Unusual Resident-Initiated Extensions - Additional Duty
Care of a single patient defined: Continuity for severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family.) Residents must appropriately hand over care of all other patients to the team responsible and document reasons for remaining to care for the single patient in question in the MedHub system. The Program Director will review each submission of additional service, and track both individual resident and program wide episodes of additional duty.

Senior Resident and fellow - Preparation to Enter Unsupervised Practice of Medicine
Residents in the final years of education [as defined by the ACGME (Internal Medicine) Review Committee, must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must with the 80 hour, 28 hour and Day off standards. There may be circumstances [as defined by the Review Committee] when senior residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than 8 hours away from the hospital will be monitored by the program director.

Jeopardy Policy
Every resident is expected to participate in the jeopardy call system. This system is in place to provide coverage for in-house duties for residents who have emergency situations. This would include sickness, family emergencies, and other unexpected absences. This is not intended for coverage for predictable absences (i.e., pregnancy leave, paternity leave, scheduled surgeries, vacations). The Chief Medical Residents will assign jeopardy call based on rotations and vacations schedules so that no work rules violations occur and vacation time is not impacted. Failure to be available for your jeopardy duties is not acceptable and can be considered grounds for probation depending on the situation. A resident who misses 1st jeopardy takes either a ward day or a 24 hour call cycle, as determined by the resident who got called in for 2nd jeopardy. The details of the jeopardy system and the jeopardy schedule are available on the residency website, http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/intmed/imrp/SCHEDULES/Pages/JeopardyGuidelines.aspx

Rotations Away
A rotation away is defined as away from University of Colorado Denver, the four core hospitals, their clinics and their faculty.
1. Pending approval of the Graduate Medical Education Office, Program Director, and the local Residency Committee a resident may take up to 3 months of away rotations during 3 years of residency. Away rotations will only be considered for approval if they consist of unique educational experiences that cannot be duplicated at one of our core sites. The last month of residency may not be used for rotations away.

2. The supervisor of each away rotation must agree in writing to supervise and evaluate the resident. This agreement must be received before approval.

3. Residents will not be permitted to participate in away rotations if participation would preclude attendance at a minimum of 130 continuity clinic sessions.

Medical Records Policy for Internal Medicine Housestaff

- Housestaff are required to complete all medical records and dictations prior to leaving a rotation site and prior to any scheduled vacations. Dictations should be routinely completed within 24 hours of the completed patient care for inpatients, and the same day of service for outpatient care.

- Each hospital monitors resident completion of discharge summaries. Residents are expected to complete discharge summaries in a timely fashion to facilitate excellent patient care and safe transitions. Each site contacts residents who have delinquencies. Each site informs the PD of residents who have either a large number of delinquent records or a long delay in dictation. The program director contacts these residents. Further delays lead to a notice of focused review indicating poor professionalism and residents are pulled from their clinical service to complete the delinquent records (necessitating coverage by their peers through our jeopardy system). A 2nd notice of delinquency leads to an official letter of warning. A 3rd notice leads to probation.

- The Program Director, Site Director and Chief Medical Resident at each institution will be notified of any residents with delinquent medical records, and may require the resident to leave their current clinical duties in order to complete the overdue records within 24 hours. The jeopardy call schedule will be implemented to provide resident coverage if necessary, and the resident with incomplete records will be required to provide reciprocal jeopardy coverage for the covering resident in the future. The site director will inform the program director if delinquent records are not complete within 3 days of notifying the resident.

- Failure to complete all medical records within 3 days of notification of delinquency, will result in the following consequences:
  - Deficient evaluation of the resident in the patient care and professionalism competencies for that rotation.
  - An official letter of deficiency written by the program director will be placed in the resident’s permanent file.
  - Possible probation.
  - Possible suspension of medical staff privileges for the attending physician of record.

Dress Code Policy

Housestaff should be easily recognizable as a physician – name badges and white coats should be worn at all times that clinical duties and/or patient care are being provided. Housestaff should pay attention to personal hygiene and should be neat, clean, and presentable at all times. Scrubs should only be worn while on call, post-call, or performing procedures or in clinic/hospital areas where scrubs are the norm for the dress code. Specific dress codes for each site, including affiliated sites, can be found online and should be adhered to. Scrubs should not be worn to clinic. Clothing that is not acceptable at any time includes: shorts or cut-offs, sweat suits, T-shirts, metallic fabric,
tank/halter/tube tops, warm-up suits, spandex or leggings alone, mini-skirts shorter than mid-thigh, tops that allow for a bare midriff. Additional detail can be found under the professionalism policy below.

4D. Policy for Recruitment, Eligibility, Selection, and Appointment of Residents

GME Eligibility and Selection Policy
The University of Colorado SOM Internal Medicine Training Program complies with the GME Policy regarding Eligibility and Selection, linked above, and program specific information is as follows:

1. Graduation from a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME); or
2. Graduation from any college of College of Osteopathic Medicine accredited by the American Osteopathic Association (AOA); or
3. Graduation from medical school outside of the United States or Canada and possessing a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, have a full and unrestricted license to practice medicine in Colorado; or
4. Graduation from medical schools outside the United States and completion of a Fifth Pathway Program provided by an LCME - accredited medical school.
5. Residents in our program must be a U.S. citizen, lawful permanent resident, refugee, asylee, or possess the appropriate documentation to allow Resident to legally train at the University Of Colorado School Of Medicine.
6. Applicants must be eligible for either a training certificate or a permanent medical license as granted by the Colorado Board of Medical Examiners (CBME).

Selection from eligible applicants is based on criteria such as:

1. Ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity, and the ability to function within parameters expected of an internist.
2. Written verification of acceptable previous educational experiences and an acceptable statement regarding the performance evaluation of the transferring resident prior to acceptance into the program.
3. Applicants will be reviewed and selected in a manner consistent with provisions of equal opportunity employment and must not be discriminated against with regard to sex, race, age, religion, color, national origin, disability or any other applicable legally protected status.
4. All applicants must participate in the National Resident Matching Program

4E. Evaluations and Promotion Policy
The University of Colorado SOM Internal Medicine Training Program complies with the GME Evaluation and Promotion Policy linked above and the program policy is as follows:

Evaluation of residents during training
The performance criteria on which housestaff will be evaluated mirror the expectations outlined above 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 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

4Ei. Program Evaluation Process

Any resident participating in training will be provided, at a minimum, a semi-annual formal evaluation developed by the Program Director (PD) or one of the Associate Program Directors (APD). Residents shall be allowed to review semi-annual evaluations contained in permanent records and other evaluations as determined by program policy. Residents have access to rotation evaluations done online on themselves at any time, and they can request to review evaluations independent of PD/APD meetings by calling the housestaff office to let them know with one day advance notice. The purpose of rotation evaluations is to lead to progressive improvement in performance and competency, and as such, all evaluations are competency-based. All evaluations done by housestaff of faculty will be confidential using the on-line assessment form, and no faculty will receive evaluations from housestaff until a minimum of five evaluations are collected to help assure anonymity. At no point will faculty be allowed to evaluate housestaff based on housestaff evaluations of them – these evaluations are separate. Evaluations must be completed within 10 days of finishing a rotation. Documentation of ongoing failure to do evaluations of staff or rotations could be grounds for probation.

The formal written evaluation shall:

- Address each of the six ACGME core competencies using milestone-based assessments as determined by the ACGME Internal medicine curricular milestones
- Include well defined scoring and rating criteria that seek to minimize subjective assessment of performance and are competency-based.
- Include language indicating proficiency and levels of supervision required, advancement to the next level of training (if applicable) or provide specific actions and performance requirements by the resident to return to a level of satisfactory performance or advancement to the next level of training.
- Be signed and dated by the resident and Program Director.
- Become a part of the permanent record file for the resident.

In the event that academic status of a resident is changed to Probation or Termination a letter of notification to the resident will be co-signed by the Associate Dean for GME. Additional information is provided in the institutional and Departmental policies titled “Grievance Policy and Procedure”.

The Program Director will formulate a summative evaluation, in addition to a yearly written evaluation, of all graduating housestaff that will include a review of the resident’s performance. This will become part of the permanent record maintained by the institution.
All faculty will be evaluated by the program annually. This will include a review of their teaching abilities, commitment to the program, knowledge, and scholarly activities. This evaluation will include the confidential evaluations of them by the housestaff.

Evaluation of Program:
The residents and faculty evaluate the program confidentially using the residency management system annually. The residents and faculty meet yearly to evaluate the overall program which includes a systemic review of the above, the curriculum, faculty development and graduate performance. An annual program improvement plan is created with input from the faculty and residents.

Clinical Competency Committee
The program Clinical Competency Committee assesses and provides input regarding resident performance to be incorporated into the semiannual/quarterly review process. The CCC makes the ultimate determination of whether a resident at any level of training is ready to advance to the next level of training and/or graduate from the program into unsupervised practice.

4Eii. Program Promotion/Advancement/Graduation Criteria

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. 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 Committee (RC) 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.
- 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 RC 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 RC 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.
- 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 RC.

PGY 1 (Internship)

The internship year focuses on closely supervised patient evaluation and management, largely based on inpatient rotations. The year consists of 4 week rotations with a week of clinic or vacation interspersed. Seven to eight blocks are spent on inpatient ward teams with in-house call occurring no more frequently than every fourth night. The remainder of the months are spent on a combination of Ambulatory Medicine, Day Float, and subspecialty medicine rotations.

1. The intern will achieve the ability to evaluate patients independently by means of comprehensive history and physical examination and supervised ordering of diagnostic tests

2. The intern will demonstrate the ability to formulate a clinical assessment and treatment plan under the close supervision of a more senior resident and attending physician

3. The intern will write admission and subsequent orders under the supervision of a more senior resident or attending physician and will arrange for appropriate disposition and follow-up care of patients.

4. The intern is expected to complete all medical records in a timely fashion, and is expected to comply with all necessary documentation that is designed to track the activities of the program, including admission logs, duty hours and procedure documentation.

5. The intern will learn and develop, with supervision, procedural skills that are essential for the practice of Internal Medicine:
   - peripheral venous catheter insertion and venipuncture
   - central venous (jugular or subclavian) catheter placement
   - thoracentesis
   - abdominal paracentesis
   - lumbar puncture
   - arterial puncture and catheter placement
   - pap smears
   - arthrocentesis

The performance of these and other procedures will be documented by the intern in a procedure log in MedHub that may be reviewed by the program director.
6. The intern must be qualified and physically able to perform basic and advanced cardiac life support, and to respond to medical emergencies.

7. The intern will teach third and fourth year medical students clinical medicine relevant to their patients. The intern will provide written evaluation of the student’s performance.

8. The intern will provide monthly written evaluations of attending physicians, residents, and each rotation.

9. The intern will provide comprehensive patient care in the outpatient setting through 1-2 half days a week of continuity clinic supervised by an attending physician except as outlined in the continuity clinic guidelines.

10. The intern will actively participate in the required intern Journal Club on a regular basis.

11. The intern will attend and successfully complete the required simulation training at the assigned VA simulation center.

12. The intern will complete the required in-training exam of the ACP and if medical knowledge deficits are demonstrated will participate in a learning plan as deemed necessary by the residency program.

Summary

At the conclusion of the first year of training, the intern must be able to evaluate and propose treatment plans for patients with a broad range of problems in Internal Medicine, under the supervision of an upper level resident or attending physician. The intern is expected to have developed effective oral and written communication skills essential to the delivery of competent patient care. The intern is expected to demonstrate respect and compassion for patients and colleagues along with a commitment to ethical standards in the practice of medicine. The intern must be able to demonstrate progress or competence in performing the key procedures listed above.

**PGY II (Junior resident)**

The junior resident year emphasizes management of a broad range of medical problems similar to the first year, along with increased responsibilities to include the direct supervision and teaching of first year residents and medical students. The junior resident may make independent assessments and decisions about treatment under the supervision of an attending physician. The PGY II year is composed of 6-7 months of inpatient rotations and 5-6 months of a variable combination of subspecialty electives, preceptorships, and research rotations.

1. The junior resident will achieve the ability to provide comprehensive patient care in both general medical and intensive care settings. Supervision is provided by an attending physician who will be available for discussion or examination of patients at all times.

2. The junior resident will supervise and teach interns and medical students, and provide written evaluations of them. The junior resident will be expected to serve as an effective team leader with the capacity to triage patients and delegate responsibility.

3. The junior resident is expected to demonstrate effective oral and written communication skills in all interactions with colleagues, ancillary personnel, and patients.
4. The junior resident is expected to complete all medical records in a timely fashion, and is expected to comply with all necessary documentation that is designed to track the activities of the program, including admission logs, duty hours and procedure documentation.

5. The junior resident will achieve competence in the performance of procedures essential to the practice of medicine (as detailed above for PGY I) and may perform procedures without direct supervision after being qualified to do so by performing the appropriate number of supervised procedures.

6. The junior resident will provide comprehensive outpatient care in the continuity clinic setting 1-2 half days a week.

7. The junior resident will be certified in BCLS and ACLS.

8. The junior resident will perform acceptably in the opinion of the department on the required in-training exam of the ABIM.

9. The junior resident will prepare an abstract or other scholarly product (most frequently for submission to the national, state, and local competitions of the American College of Physicians or the Rocky Mountain Hospital Medicine Symposium).

10. The junior resident will participate in the required Journal Club on a regular basis.

Summary:

At the completion of the second year, the junior resident must be able to evaluate and treat patients with all degrees of severity of general medical illnesses with the readily available guidance of an attending physician. The junior resident must be able to supervise a team of interns and students in the evaluation and care of patients, and to teach the interns and students general and specific aspects of this care.

PGY III (Senior resident)

The senior residency year emphasizes the semi-independent management of patients in the hospital and ambulatory settings with review by supervising attending physicians. The senior resident will complete 3 months of inpatient rotations and 9 months of a combination of outpatient rotations, subspecialty electives, float, emergency medicine, neurology, preceptorships and research.

The senior resident will be expected to perform all the functions of a junior resident (see PGY II description) along with a progressive responsibility in patient care/management decisions, team leadership, and supervision and teaching of students and interns.

1. The senior resident will achieve the ability to evaluate and manage patients with a broad range of medical problems and all degrees of severity, in both the inpatient and outpatient setting in a semi-autonomous fashion, with the supervision and continuous review of an attending physician.

2. The senior resident should possess sufficient knowledge and experience to efficiently triage patients and provide medical consultations to non-medical services.
3. The senior resident is expected to have documented competence in the performance of procedures essential to the practice of Internal Medicine, and to supervise more junior residents in the performance of such procedures.

4. The senior resident is expected to complete all medical records in a timely fashion, and is expected to comply with all necessary documentation that is designed to track the activities of the program, including admission logs, duty hours and procedure documentation.

5. The senior resident will prepare an abstract or other scholarly product (most frequently for submission to the national, state, and local competitions of the American College of Physicians or the Rocky Mountain Hospital Medicine Symposium).

6. The senior resident will participate in required Journal Club on a regular basis.

7. The senior resident will provide comprehensive patient care in the outpatient setting through 1-2 half days a week of continuity clinic supervised by an attending physician.

Summary

By the completion of three years of training, the senior resident must demonstrate competence in managing a diverse range of problems in Internal Medicine, and will be prepared to enter unsupervised practice or further training in a subspecialty.
4F. Leave Policy

The internal medicine residency training program complies with the GME policy regarding Resident/Fellow Leave, linked above. The program leave process is outlined below.

Policy for Medical/Parental/Military/Family Leave
Leave for Medical/Parental/Military/Family is available to all residents regardless of gender.

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.

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.

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. (Rev 5/5/11)

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 the housestaff office immediately, and if appropriate we will write a letter requesting that he/she be excused.
Vacation Policy

All housestaff are required to have any outstanding medical records and dictations completed prior to going on vacation.

Second and Third Year Residents receive 21 calendar days of paid vacation and 7 calendar days of educational leave. Interviews and academic presentations during electives count toward your 7 days of educational leave.

If and only if you are interviewing for a fellowship position or a job interview while on a consult elective with a Monday to Friday weekly resident schedule, it is ok to ask your attending and fellow if you could work a weekend day in lieu of a week day (as long as your continuity clinic is not affected).

If and only if your attending and fellow agree, please email Jennifer Weber to let the housestaff office know which specific days you will swap out. For instance, you might work Sunday thru Thursday and then go to a Friday interview without using up one of your vacation/educational leave days.

All schedule and vacation changes must be made through the Housestaff Office. No schedule changes or vacation changes can be accommodated without 60 days advance notice due to clinic scheduling. Generally, vacations are 7 calendar days from one elective. Simultaneous or multiple-week vacation requests may be approved by requesting vacation from back to back electives (i.e. one week off the end of one rotation and one week off the beginning of the next). Once the master schedule for the year is in place, however, if changes to a housestaff’s vacation schedule would affect the jeopardy call system, it will be the responsibility of the housestaff to arrange for alternate coverage of this system (not the responsibility of the Program or Chief Residents). Fellows and attendings cannot give permission for additional vacation without approval from the housestaff office. If you fail to schedule your vacations, i.e., are absent without approved leave by the Housestaff Office, you may be placed on probation. If you need to be absent for any reason please inform the Program Administrator as far in advance as possible and if you are ill, please inform the Program Administrator as well as your Chief Medical Resident, Clinic Director, and Subspecialty Director or Inpatient Director.

You must sign up for vacation at the beginning of each academic year. You may sign up for three weeks of vacation (21 calendar days) and one week of educational leave (7 calendar days). Vacations may not be taken from in-patient rotations. Vacations may be taken on elective months that do not require in-patient care. On electives on which there is no weekend call, this will automatically grow to nine calendar days. The exception is the week that the mandatory In-Training Exam is given in October. You will not be allowed to take both weekends during this time. When holidays occur within or adjacent to the vacation block, the resident will get the holiday off in addition to 7 days of vacation. These weeks will be protected from jeopardy call.

Vacation will be allowed on OBMT in November and December. Vacations will be a maximum of 2-3 days and depending on the volume, not all requests may be able to be honored. Vacations may also be allowed on OBMT for some instances of personal conflict. Each request will be handled on a case by case basis by the program administration.

Initial vacation requests will be submitted through the AMION software. Changes in vacation will require completion of a vacation change form or emails from the chief resident in charge of the jeopardy schedule, rotation coordinator and your clinic director. Vacation cannot be carried over to the next academic year.
4G. MOONLIGHTING POLICY

GME Moonlighting Policy

The University of Colorado SOM Internal Medicine Training Program recognizes that moonlighting is not an activity associated with part of the formal educational experience and complies with the GME Moonlighting Policy linked above. The GME Moonlighting Approval Form must be completed and approved prior to engaging in moonlighting activities. All moonlighting and additional pay for additional work hours must be logged in Med Hub and count toward duty hours.

For reference, the GME Additional Pay for Additional Work Policy and Approval Form are provided and linked below:

GME Additional Pay for Additional Work Policy  GME APAW Approval Form

R-1 Moonlighting is prohibited at any time without exception.

R-2 Moonlighting is prohibited while on ward rotations without exception. Moonlighting is strongly discouraged while in specialty rotations. Under unusual circumstances of financial need, permission to moonlight may be requested from the Program Director and the Department Chairman for approval by the Residency Committee.

R-3 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 for Friday/Saturday 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, warning, or probation will not be allowed to moonlight without exception, in accordance with the GME rules.
4H. Impaired Physician Policy/ Substance Abuse Policy

The University of Colorado SOM Internal Medicine Training Program complies with the GME Physician Impairment and Health (Substance Abuse) Policy.

The Department of Medicine follows the University of Colorado institutional policy on alcohol and drugs which states “it is a violation of University policy for any member of the faculty, staff, or student body to jeopardize the operation or interests of the University through the use of alcohol or drugs. Sanctions…may include expulsion and/or termination of employment.”

If a housestaff’s behavior is considered potentially dangerous to patients, immediate suspension of clinical duties may be imposed at the discretion of the Program Director. All housestaff suspected of impairment will be referred to the Colorado Physician Health Program (303-860-0122). This is a confidential referral and program. If warning signs as below become apparent, the program reserves the right to intervene and refer to CPHP.

Warning signs of impairment can include but are not limited to:
- inappropriate or abnormal behavior on rounds
- decreasing performance, including failing to show up on time
- inappropriate prescribing
- becoming the subject of complaints or gossip
- behavior such as hostility, isolation or withdrawal
- increasing patient complaints
- legal problems, including driving arrests
- relationship problems
- financial problems that are new
- poor hygiene or lack of attention to grooming
- emotional crises, especially if frequent, numerous, or severe
- multiple physical complaints or symptoms
- self-prescribing

4i. Professionalism Policy
The University of Colorado SOM Internal Medicine Training Program complies with the GME Professionalism Policy linked here. All residents will sign a paper indicating they have seen and understand this policy as well as our additional policy (noted below - Internal Medicine Residency Program Policy of consequences for noncompliance with program requirements). These will be placed in their residency files.

All residents/fellows must abide by the professionalism principles and guidelines as stated by the ACGME program requirements and as detailed in the GME Professionalism Policy. In addition,
professionals are held accountable to the following specialty-specific board and/or society codes of medical professionalism.

The program director and faculty monitor resident 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.

The program provides the following professionalism education to residents:
Residents and fellows are provided professionalism education via GME New Resident Orientation and modules, program didactic conferences and department grand rounds, intern Wednesday morning professionalism series.

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:

a. 1st offense – Email or written notice of delinquency for failure to meet professionalism standards (focused review)
b. 2nd offense – Letter of Warning
c. 3rd offense – Probation (permanent part of training file)

4j. Quality Improvement and Safety Guidelines/Expectations
The University of Colorado SOM Internal Medicine Training Program complies with the GME Quality Improvement and Patient Safety Policy linked here.

Introduction:
In accordance with ACGME Common Program Requirements, residents must “systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.” As such, “The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.”

The University of Colorado Denver School of Medicine (UCDSOM) Graduate Medical Education Committee (GMEC) requires each ACGME accredited residency and fellowship program develop policies to ensure all residents are involved in Quality Improvement/Patient Safety (QI/PS) activities.

Definition:
Quality Improvement/Patient Safety activities include but are not limited to the following:

- Individual Practice Assessment and Improvement Plan
- Each resident identifies both a preventive measure and chronic disease measure in their continuity clinics
- They conduct an audit of their practice to assess compliance with guidelines and outline a goals and plans for improvement
- Quality Improvement/Patient Safety Conferences (e.g., Morbidity and Mortality)
- These conferences will be facilitated by faculty members to allow for discussion of both cognitive errors and systems factors
- All residents are required to attend
- Participation in institutional Quality Management Committees
- Participation in efforts to achieve Patient-Centered Medical Home (PCMH) designation in ambulatory clinics
- Each resident will have the opportunity to work on QI projects with their continuity clinics to achieve required metrics for receiving PCMH designation
- Participation in relevant longitudinal QI projects with clinical partner (e.g. improvement of quality of transitions of care)
- Elective Quality Improvement rotations
- Scholarly activity resulting in implementation of initiatives to improve patient quality and safety of care

Policy:
Each residency and fellowship program must ensure each resident participates in Quality Improvement/Patient Safety activities. The level of participation will vary depending on the functional role of the resident or fellow in patient care and the QI/PS activities currently underway within the clinical setting and institution.

1. At a minimum, every training program must incorporate Quality Improvement/Patient Safety Conferences (a.k.a., Morbidity and Mortality) into its curriculum, including use of the prescribed Patient Safety/M&M/Occurrence Review Form if applicable to the institution.
2. At least annually, in conjunction with the Annual Program Evaluation, the Designated Institutional Official for GME will provide the GMEC with a report of QI/PS activities as they pertain to the residents and the teaching programs.
3. The DIO will address any concerns identified regarding insufficient QI/PS involvement.

All interns will attend the QI lecture series designed by Dr. Tad-Y and will be responsible for the “QI deliverables” reviewed during those sessions. 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.

Example:
Each resident is responsible for a quality improvement/patient safety project during his/her residency. These will largely be coordinated at each trainees’ clinic site, but residents can achieve these on inpatient services or in combination locations.

The Program also participates in Quality Improvement/Patient Safety Conferences (e.g., Morbidity and Mortality).

Some examples of quality improvement projects include:
Improving Transitions for the Underinsured in Denver
Decreasing PNA Readmissions
Developing a standardized pre-operative evaluation in the clinic
Improving the medication reconciliation process in clinic
Improving diagnosis of coagulation disorders in the outpatient setting.
Improving documentation of diabetic patients’ self-management plans
Increasing # of patients with controlled HTN through increased use of Hypertension Clinic
“Do No Harm”
Optimizing CAD Care for patients in the Lowry Clinic
Implementing geographic cohorting in an inpatient setting
Creating a patient-centered education/experience during med-rec at discharge from the ACE unit
Improving accuracy and efficiency of med-rec workflow at admission to the ACE unit
Best Practice for Patient Safety Reporting

Depression Management Study
Health Literacy and Intensive Care Management
Impact of Colfax Schedule on Continuity of Care and Resident, Patient Satisfaction
Virtual Preceptor

4k. Research/Quality activities guidelines/expectations

All residents have the opportunity to take research time during residency. An approved research form must be filled out and approved in advance – there are separate forms for categorical research versus Primary care research and both are available on the Internal medicine resident website (PC form below). Research counts towards non-clinical time (even though residents are required to go to their continuity clinic during research months), and as such in order to remain ABIM board eligible, a maximum of 3 months total non-clinical time is allowed during residency (there are other electives that are considered non-clinical so they must be accounted for in this total). It is expected that all research be written up and/or presented at the completion of projects.

PC Research form

4l. Supervision of Residents

The University of Colorado SOM Internal Medicine Training Program follows the GME Supervision Policy linked above.

To ensure that residents are provided adequate and appropriate levels of supervision during the course of the educational training experience and to ensure that patient care continues to be delivered in a safe manner and to ensure oversight of resident supervision and graded authority and responsibility, the program follows the ACGME classification of supervision (CPR VI.D.3):

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

**Indirect Supervision:** With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

**With Direct Supervision Available:** The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The program maintains current call schedules with accurate information enabling residents at all times to obtain timely access and support from a supervising faculty member.

The Program Director will ensure that all program policies relating to supervision are distributed to residents and faculty who supervise residents. A copy of the program policy on supervision is included in the official Program Manual and provided to each resident upon matriculation into the program.

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 and 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. [http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/intmed/imrp/POLICY/Documents/Procedure%20Supervision-rev%2010%2026%2011%20sbran.pdf](http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/intmed/imrp/POLICY/Documents/Procedure%20Supervision-rev%2010%2026%2011%20sbran.pdf)

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).
4m. Program Handoff Process

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<thead>
<tr>
<th>Policy: Transitions of Care (Structured Patient Handoffs)</th>
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<tr>
<td>Original Approval: Draft to EAC, March 13, 2012</td>
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<td>Effective date:</td>
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Introduction:
The University of Colorado Denver School of Medicine (UCDSOM) Graduate Medical Education Committee (GMEC) requires each residency and fellowship program to develop policies to ensure the safe transfer of responsibility for patient care. The format for transfer of care may vary, but each program's standards must ensure continuous, coordinated delivery of care in settings that are appropriate to patients' needs, including arrangements that extend beyond the inpatient setting into the community and the home.

Definition:
A structured handoff is the process of transferring information, authority, and responsibility for patients during transitions of care. Transitions include changes in providers (shift to shift, service to service) or when a patient is moved from one location or level of service to home or another level of care. Transitions may also be prompted due to caregiver fatigue.

Policy:
Each residency and fellowship program must develop a Transition of Care (Structured Patient Handoff) Policy that outlines the expectations for transfer of responsibility for patient care in all the settings/situations in which handoffs occur. The amount of information to be included in the process will vary depending on the functional role of the resident or fellow in patient care and the requirements of the clinical setting and facility. Residents and fellows providing continuous and direct care and taking responsibility for order writing require a higher level of information exchange than those with less continuous duties, such as consultative or supervisory services.

Per ACGME Common Program Requirements (VI.B. Transitions of Care), each program must:

1. Design clinical assignments to minimize the number of transitions in patient care.
2. Ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
3. Ensure that residents and fellows are competent in communicating to the team members in the hand-over process.
4. Work with the sponsoring institutions to ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient’s care.

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 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 written template should be consistent between sites and expected to contain the most updated information at every transition of care.

Commonly Used Handoff Mnemonic SAIFIR

Off-going provider performs a SAIF handoff
- Summary Statement
- Active Issues
- If-then contingency planning
- Follow-up

On-coming provider makes the handoff SAIF-IR
- Interactive Questioning
- Read Backs

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.

4K. USMLE and COMLEX Exams
The internal medicine residency program complies with the GME Policy on USMLE (and COMLEX) Examinations.

5. ACGME Specific Program Requirements
The program will comply with and provide current ACGME program requirements within this Program Manual annually – link below.
http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/140_internal_music07012009.pdf