# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Educational Goals</td>
<td>2</td>
</tr>
<tr>
<td>Curriculum - description</td>
<td>3</td>
</tr>
<tr>
<td>- Categorical Medicine</td>
<td>3</td>
</tr>
<tr>
<td>- Preliminary Medicine</td>
<td>4</td>
</tr>
<tr>
<td>Procedures</td>
<td>5</td>
</tr>
<tr>
<td>Required Conferences and Meetings</td>
<td>7</td>
</tr>
<tr>
<td>General Competencies</td>
<td>8</td>
</tr>
<tr>
<td>Evaluation of Residents</td>
<td>11</td>
</tr>
<tr>
<td>Advisor Program</td>
<td>13</td>
</tr>
<tr>
<td>Attending Faculty Teaching Expectations</td>
<td>14</td>
</tr>
<tr>
<td>Resident Responsibilities, Program &amp; Accreditation Rules</td>
<td>15</td>
</tr>
<tr>
<td>Supervisory Reporting Process – interns, seniors, faculty</td>
<td>20</td>
</tr>
<tr>
<td>On Call Hours &amp; Responsibilities</td>
<td>22</td>
</tr>
<tr>
<td>WMC Night Float / Emergency Medicine Rotation</td>
<td>27</td>
</tr>
<tr>
<td>VC Night Float Rotation</td>
<td>29</td>
</tr>
<tr>
<td>Continuity Clinic/Week Schedule</td>
<td>30</td>
</tr>
<tr>
<td>Resident Leave Policy</td>
<td>31</td>
</tr>
<tr>
<td>Moonlighting/Locum Tenens</td>
<td>34</td>
</tr>
<tr>
<td>Recognizing Resident Fatigue</td>
<td>36</td>
</tr>
<tr>
<td>Protocol For Professional Liability Actions</td>
<td>38</td>
</tr>
<tr>
<td>Protocol When Involved In Malpractice Activity</td>
<td>38</td>
</tr>
<tr>
<td>Reporting Obligations Under The House Bill 2661</td>
<td>38</td>
</tr>
<tr>
<td>Universal Blood And Body Substance Precautions</td>
<td>44</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
</tr>
<tr>
<td>A. Administrative Staff in the Department of Internal Medicine</td>
<td>45</td>
</tr>
<tr>
<td>B. ACGME General Competencies/ACGME Milestones</td>
<td>46</td>
</tr>
<tr>
<td>C. Grand Rounds Preparation Guidelines / Evaluation Form/Curricular Milestones</td>
<td>54</td>
</tr>
<tr>
<td>D. Evaluation Forms</td>
<td>57</td>
</tr>
<tr>
<td>E. WCGME Grievance Process Guidelines for Residents</td>
<td>72</td>
</tr>
<tr>
<td>F. Excessive Census Plan</td>
<td>76</td>
</tr>
<tr>
<td>G. Residency Administrative Forms</td>
<td>77</td>
</tr>
<tr>
<td>H. Practice Based Learning</td>
<td>84</td>
</tr>
<tr>
<td>I. Handoff Process</td>
<td>85</td>
</tr>
</tbody>
</table>
PROGRAM EDUCATIONAL GOALS

The residency program at the University of Kansas School of Medicine-Wichita (KUSM-W) prepares residents to practice general internal medicine (see Appendix A; Administrative Staff). The goal is to enable residents to acquire the knowledge, skills and behavioral attributes necessary for success as a general internist, including compassionate, professional, comprehensive care of patients in all health care settings including the acute care hospital, longitudinal ambulatory settings, long term care homes, hospice facilities and other facilities.

The program provides residents with a broad knowledge and skills base in general internal medicine, medicine sub-specialities, and related specialties pertinent to the practice of general internal medicine. Residents acquire the skills, knowledge, and judgment needed for direct patient care and for determining when additional consultative assistance is necessary from other health care professionals. The program also gives residents experience providing consultative care for other health care providers. In addition to the knowledge base required of general internists, residents should acquire expertise in the efficient acquisition and assessment of clinical data and cost-effective therapeutic intervention. The educational format assures residents the opportunity to evolve interviewing and physical diagnosis technique and technical procedural competence.

The program emphasizes the professional etiquette, behaviors, and humanistic aspects of medical practice essential to patient care, including the ability to function effectively as part of the patient care team comprised of both medical and paramedical personnel including the ability to analyze systems deficiencies and effect solutions. The program nurtures each resident's personal commitment to professional growth, scholarship, lifelong learning, self-reflection and self-improvement. The program insists on resident involvement and competency in quality improvement and patient safety. Because the residency program at KUSM-W provides education in both rural and urban settings, graduates may function competently in both tertiary hospitals as well as primary care settings.

All residents must achieve the competencies required by the Accreditation Council of Graduate Medical Education (see Appendix B).

**Preliminary Medicine.** The preliminary medicine year provides first-year residents the opportunity to develop the clinical skills, knowledge, behavioral attitudes, and professional behavior expected of a postgraduate trainee. It prepares them to enter a subspecialty that requires such a year or continue with internal medicine. Experiences will occur in both the inpatient and outpatient setting.

**Medicine/Pediatrics.** The Med/Peds program is sponsored jointly by the Department of Internal Medicine and the Department of Pediatrics. The program prepares residents for board certification in both medicine and pediatrics. Med/Peds is a four-year curriculum with 24 months required in each specialty. Throughout the 4 years, residents rotate in each specialty four months one year and eight months during the alternate year or vice versa.
Curriculum

Categorical Medicine - 4 + 1 Schedule

PGY 1
Inpatient General Medicine* 4-6 months
Night Float 1 month
Medicine and Subspecialty Electives 2 – 3 months
Geriatric Medicine 1 month
Critical Care/ICU 1 month
Continuity Ambulatory Care Clinic 1 week, every 5th week
*Number of inpatient months may vary.

The goals are to foster the knowledge, attitude/behavior and skills necessary to provide first-contact patient care, refine abilities to interview and examine assigned patients, prepare problem lists, synthesize initial differential diagnoses, outline efficient diagnostic and therapeutic interventions, and complete discharge and follow-up care plans for patients. First-year residents also develop skills in cardiopulmonary resuscitation and assessing acutely ill hospitalized patients during codes and rapid responses. Residents also begin to develop a cohort of outpatients for which they provide longitudinal primary care. All patient care is supervised by faculty. In addition, residents are assigned to a Night Float rotation at Via Christi St. Francis (see page 29).

PGY 2
Medicine and Subspecialty Electives 3-4 months
Critical Care/Inpatient General Medicine, Supervisory 1-2 months
Night Float 1 month
Critical Care/ICU 2 months
Emergency Medicine 1 month
HIV/Acute Care Clinic 1 month
Continuity Ambulatory Care Clinic 1 week, every 5th week

During the second year, residents assume supervisory responsibilities for first-year residents while on-call and become the resident in charge of coordinating and monitoring cardiopulmonary resuscitation events occurring in the hospital during their call periods. They will also assume supervisory responsibilities on an inpatient medicine or critical care rotation. Resident ambulatory skills are augmented by an obligatory ambulatory care rotation which is divided into blocks of one week occurring every 4 weeks (4 + 1 schedule). This rotation promotes management skills in focused ambulatory care that may include office gynecology, adolescent medicine, rehabilitation medicine, orthopedics, medical ophthalmology, otorhinolaryngology, dermatology, and geriatrics. They will also have one month of acute care. Residents also obtain practical experience in acute emergency care via a one-month rotation in an Emergency Department in which the resident has first-contact care duties and must assist in making decisions regarding triage, hospital admission or dismissal from the emergency unit. Residents also care for patients with HIV/AIDS during a one month rotation at the KUSM-W Midtown Clinic while completing their acute care month (AM clinic in acute care and PM clinic in HIV/AIDS clinic). The remainder of the second year is comprised of subspecialty internal medicine rotations. Although residents provide first-contact care for patients admitted to subspecialty services, they also learn the role and etiquette of the medical consultant by providing subspecialty consultation for other physicians. In all these experiences, residents learn the importance of teamwork with other professionals in the health care setting. All patient care activities are supervised by faculty. In addition, second year residents are assigned to a Night Float rotation at Wesley Medical Center working 1-2 week blocks of consecutive nights for a total of 4-5 weeks throughout the year (see page 27). Residents are also assigned to a one-month neuro-critical care rotation at Via Christi Hospital, which is usually divided into 2, two-week blocks. During this rotation, they are exposed to a unique subset of patients and learn to manage neurological emergencies.
PGY 3
Inpatient General Medicine, Supervisory* 5-6 months
Night Float (instead of call) 2 weeks
Medicine and Subspecialty Electives 4 months
Critical Care/ICU, Supervisory 1 month
Continuity Ambulatory Care Clinic 1 week, every 5th week
*Number of inpatient months may vary.

In the third year, residents supervise first-year residents and medical students on the general medicine hospital services and while on hospital call. Senior residents also function as general internal medicine consultants to obstetrical, psychiatric, surgical, and other services and continue to refine their consultative skills. In the supervisory capacity, senior residents are integral to the organization and successful function of general medicine teaching services. They hone their leadership capabilities by assuming direct responsibility for the patient care delivered by first-year residents as well as the activities of medical students assigned to the service. Residents are granted considerable independence and decision-making authority for both emergency department patient encounters and consultations requested of subspecialty services. Nevertheless, all patient care is supervised by faculty physicians.

**Preliminary Medicine - 13 Block Schedule**

Preliminary residents enhance their history taking, interviewing, and physical examination skills. They prepare concise problem lists, formulate an initial differential diagnosis, develop an initial follow-up plan, establish a diagnostic plan, and develop initial therapeutic and ongoing treatment plans. They also develop discharge planning skills and outpatient follow-up skills. Preliminary residents may choose to participate in the half-day continuity clinic required of categorical residents. They learn the procedures expected of a first-year resident, including common procedures such as phlebotomies, IV insertion, and advanced procedures, including central line placement, and arterial puncture. In addition, residents are assigned to a Night Float rotation at Via Christi St. Francis (see page 29).

**Rotations for Preliminary Internal Medicine**

Inpatient General Medicine* 6 – 7 months
Night Float 1 week
Medicine and Subspecialty Electives 6 – 7 months
*Number of inpatient months may vary.

**Scholarly Activities**

Residents are required to pursue scholarly activities during their training. Several activities in clinical research are available. Investigative activities also include literature reviews, case reports, clinical quality improvement studies, and chart reviews.

PGY 2 and PGY 3 residents are required to prepare scholarly, faculty-mentored presentations at the annual regional ACP-ASIM conference every fall. PGY-2 and PGY-3 residents also are required to prepare a Grand Rounds lecture each year (see Appendix C). The Department of Internal Medicine will cover the preparation cost of having images scanned or slides created up to, but not exceeding $50.00 per resident presentation. Any additional cost will be the responsibility of the resident. Educational allowance funds may be utilized for any overage.

**Systems Based Learning & Practice Based Learning**

All residents participate in structured programs to develop skills in SBL and PBL. Each resident must demonstrate basic competency in these areas. These programs run concurrently in their rotation assignments but often involve patient experience on their assigned rotations.
Throughout the three-year KUSM-W residency, residents accrue technical procedural expertise necessary for modern general internal medicine practice. Resident procedural qualifications are monitored and certified by appropriate faculty and a database of their procedural skills is maintained. Residents must perform all procedures under the supervision of faculty, other qualified health care providers, or another resident who has demonstrated competency previously in performing the procedure. After the procedure has been completed, the supervisor must complete the procedure documentation.

Indications/contraindications and complications must be listed on the procedure card for the resident to receive credit for the procedure. Residents should return the completed procedure card to the residency office.

After the resident has demonstrated proficiency at the procedure, completed the minimum number of qualifying procedures, and demonstrated knowledge of the indications, contraindications and complications of the procedure, he/she may perform subsequent ones without direct supervision and may supervise other residents or students in these procedures. For certain invasive procedures, individual hospitals may restrict unsupervised resident activity regardless of authorization by the Internal Medicine Program Director (see Appendix D). A procedure form can also be obtained from the internal medicine website – http://wichita.kumc.edu/im/resident/Procedure_Card_2013.pdf

Requirements for graduation:
All residents must demonstrate the ability to perform safely and competently Advanced Cardiac Life Support (ACLS), drawing venous blood, drawing arterial blood, pap smear and endocervical culture, and placement of a peripheral venous line.

- Completion of this portion of the requirements for graduation will require that each resident maintain active ACLS certification demonstrate competence to perform each of the procedures listed above.

- A minimum number of 5 procedures must be completed for each of the procedures listed above in order for the resident to be eligible for graduation from the residency program.

All residents are also required to demonstrate the knowledge, understanding, and ability to explain the indications, contraindications, complications, use of sterile technique, pain management issues, specimen handling (when appropriate), and interpretation of results as well as knowledge in obtaining informed consent as appropriate for the following procedures:

- Abdominal paracentesis, arterial line placement, arthrocentesis, central venous line placement, drawing venous blood, drawing arterial blood, electrocardiogram, incision and drainage of an abscess, lumbar puncture, nasogastric intubation, pap smear and endocervical culture, placing a peripheral venous line, pulmonary artery catheter placement, and thoracentesis.

Completion of this portion of the requirements for graduation will be accomplished through simulation training as well as training in the critical care, inpatient, and ambulatory settings.

Elective Procedures:
While residents will be required to learn the indications, contraindications, potential complications, etc., of many other procedures, they will not be required to demonstrate competence in performing procedures outside of the requirements of the ABIM. For residents interested in obtaining training to perform procedures that are not required for graduation, opportunities will be provided for them to obtain procedural training.
In order for the resident to supervise another resident or to perform a procedure unsupervised, they must first perform the minimum number of procedures as listed below, followed by an assessment of competence to perform the procedure by either a full-time faculty member or program director.

**Minimum Required Procedures to Assess Competence:**

1. **Central Venous Line Placement:** 20 (one anatomic location)
   - 20 procedures at a specified anatomic location are required to assess competence. For example, a resident must perform either 20 Internal Jugular CVL’s, 20 Subclavian CVL’s, or 20 Femoral CVL’s before competence can be assessed. The number of procedures performed are not additive between the anatomic locations.
   - However, once a resident is deemed competent to perform either Internal Jugular CVL or Subclavian CVL placement, they may be assessed for competence at any other site after performing 5 additional CVL’s at the other specified site for which they are requesting assessment of competence. For example, a resident performs 20 Internal Jugular CVL’s and then asks their supervising attending to assess them for competence at Internal Jugular CVL placement and is subsequently granted privileges to perform the procedure unsupervised. The resident would also like to perform Subclavian CVL and Femoral CVL placement and would be required to complete 5 Subclavian and 5 Femoral CVL placements separately prior to being assessed for competence at placing CVL’s at these additional anatomic locations.
   - A resident who is deemed competent after completing 20 Femoral CVL placements would **NOT** be eligible for competence assessment at placement of Internal Jugular or Subclavian CVL’s until they had completed an additional 20 procedures at the specified anatomic location (Internal Jugular or Subclavian) for which they wish to also obtain privileges to perform unsupervised.

2. **Arterial Line Placement:** 10
3. **Thoracentesis:** 10
4. **Lumbar Puncture:** 10 (up to 5 simulation Lumbar Punctures may be performed and counted toward the total required to assess competence).
5. **Paracentesis:** 5

Additionally, it is highly recommended that residents track all procedures that they perform in order to document for future privileging requests after completion of residency. The list below is a guide to procedures that may be documented but any procedures that a resident performs that are not on the list should also be documented as well.

- Skin excision (simple), punch biopsy of the skin, suturing, joint injection, casting/splinting, mechanical ventilator management, incision and drainage of an abscess, pulmonary artery catheter placement, nasogastric intubation, toenail removal, IUD placement, and endometrial biopsy.
Required Conferences and Meetings

Residents are required to attend an on-going series of didactic conferences. A calendar of departmental conferences is distributed monthly. **Residents are expected to attend all conferences unless they have approved leave or are excused.** Conference attendance will be monitored monthly. If a resident is unable to maintain a conference attendance rate of at least 90% for each of the conferences listed below, they will be asked to undergo remediation in order to help them 'catch up' on the missed didactic portions of their residency training.

- **Morning Teaching Conference** is held Tuesday, Wednesday, and Thursday from 8:00-8:45 am. MTC during July-August will be replaced by “Boot Camp, Essentials of Medicine.” This is also held Tuesday - Thursday, 8:00-8:45am. Residents should attend Morning Teaching Conference at any of the hospital locations.

- **Hospital Grand Rounds** is held weekly at noon. Grand Rounds is held on Monday at Wesley Medical Center, Tuesday at Via Christi Health - St. Francis, and Thursday at the VA Medical Center.

- **KUSM-W Grand Rounds** is held weekly on Friday at noon usually beginning in September.

- **Board Study** is held weekly on Wednesday usually at Via Christi Health - St. Francis. Residents are expected to attend Board Study regardless of their In-Training Exam scores.

- **Journal Club** is held monthly at noon at KUSM-W.

- **All Resident Meeting** is held monthly at KUSM-W.

- **M&M** is held monthly at Via Christi Health - St. Francis.

**Excused Absences**

Residents may be excused from their assigned conferences as follows:

1. Senior Residents holding the code pager – Excused from Journal Club, All Resident Meeting, Board Study, and KUSM-W Grand Rounds*; Interns holding the code pager will be allowed to leave the hospital to attend conference.
2. Residents on Night Float.
3. Residents on department-approved leave.
4. Residents who may surpass the maximum duty hour policy.
5. Residents who must meet the one-day-in-seven-off policy – Excused from conferences.*
6. Preliminary residents are not required to attend Board Review but are encouraged to attend as an optional educational activity.
7. Residents on ambulatory block week will be expected to attend conferences per their ambulatory block schedule; all other conferences will be excused during this week.

When excused, your absence will not affect your attendance requirement. To be excused, you must notify the residency office of your reason* (#1, 4, 5 above) prior to the meeting if possible and no later than 5:00 pm on the day of the required meeting.
## General Competencies

<table>
<thead>
<tr>
<th>ACGME Category</th>
<th>Activities</th>
<th>Assessment Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td>1) Perform thorough history and physical</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Synthesize data into a problem list and differential diagnosis</td>
<td>*Continuing clinic evaluations</td>
</tr>
<tr>
<td></td>
<td>3) Formulate diagnostic and therapeutic plan with supervision</td>
<td>*Mini CEX’s</td>
</tr>
<tr>
<td></td>
<td>4) Perform basic clinical procedures</td>
<td>*Patient Survey</td>
</tr>
<tr>
<td></td>
<td>5) Demonstrate caring and respectful behavior</td>
<td>*Chart Reviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Procedure Log</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Inpatient Chart Audits</td>
</tr>
<tr>
<td><strong>Medical Knowledge</strong></td>
<td>1) Demonstrate basic knowledge of pathophysiology and disease processes</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Develop basic knowledge base for inpatient and outpatient clinical care</td>
<td>*In-Training Exam</td>
</tr>
<tr>
<td></td>
<td>3) Demonstrates the ability to access relevant clinical information</td>
<td>*Web-based assessment tools</td>
</tr>
<tr>
<td><strong>Practice-Based Learning and Improvement</strong></td>
<td>1) Develop the ability to self-evaluate educational needs and performance</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Incorporate relevant feedback and instruction into clinical activities</td>
<td>*Journal Club Test</td>
</tr>
<tr>
<td></td>
<td>3) Facilitate the learning of other learners on the care team</td>
<td>*Problem Based Learning &amp; Improvement clinic project</td>
</tr>
<tr>
<td></td>
<td>4) Use technology to enhance patient care and medical education</td>
<td>*Inpatient guideline chart review</td>
</tr>
<tr>
<td><strong>Interpersonal and Communication Skills</strong></td>
<td>1) Develop excellent communication skills</td>
<td>*Peer Surveys</td>
</tr>
<tr>
<td></td>
<td>2) Develop accurate, clear, and complete documentation skills</td>
<td>*Nurses Surveys</td>
</tr>
<tr>
<td></td>
<td>3) Learn to present a case accurately and succinctly</td>
<td>*Patient Surveys</td>
</tr>
<tr>
<td></td>
<td>4) Establish an effective therapeutic relationship with patients and families</td>
<td>*Mini CEX</td>
</tr>
<tr>
<td></td>
<td>5) Demonstrate effective listening skills</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Web-based Communication Module</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Inpatient Chart Audit</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
<td>1) Demonstrate respect and compassion</td>
<td>*Patient Surveys</td>
</tr>
<tr>
<td></td>
<td>2) Display a professional appearance</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>3) Demonstrate a commitment to ethical issues</td>
<td>*Nurses Surveys</td>
</tr>
<tr>
<td></td>
<td>4) Consider the needs of patients and families</td>
<td>*Peer Surveys</td>
</tr>
<tr>
<td></td>
<td>5) Consider the needs of colleagues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6) Demonstrate constructive and respectful working relationships with other health care professionals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7) Fulfill responsibilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8) Acknowledge errors and accept criticism</td>
<td></td>
</tr>
<tr>
<td><strong>Systems-Based Practice</strong></td>
<td>1) Develop knowledge of practice and the clinical delivery system</td>
<td>*SBL Project</td>
</tr>
<tr>
<td></td>
<td>2) Access appropriate resources</td>
<td>*Management Conference assessment</td>
</tr>
<tr>
<td></td>
<td>3) Identify error-prone system issues and needed improvements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4) Identify efficiency problems and needed improvements</td>
<td></td>
</tr>
</tbody>
</table>
Minimum requirements for advancement of residents to PGY-2 level of training:
1. Attendance at required conferences unless on approved leave or excused (90% attendance policy).
2. Satisfactory overall evaluation in all categories.
3. Achievement of general competencies.
4. No breach in contractual obligations.
5. No instances of unethical or unprofessional behavior that have not been remediated.
6. Capable of assuming supervisory responsibilities for PGY-2 level of training as determined by the Clinical Competency Committee.

**PGY-2**
The competencies below are expected when those listed for PGY1 above are achieved.

<table>
<thead>
<tr>
<th>ACGME Category</th>
<th>Activities</th>
<th>Assessment Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td>1) Coordinate patient care among all members of the health care team</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Manage patients appropriately based on available evidence, sound judgment, and patient preferences</td>
<td>*Continuing clinic evaluations</td>
</tr>
<tr>
<td></td>
<td>3) Formulate therapeutic and diagnostic plan independently</td>
<td>*Mini CEX’s</td>
</tr>
<tr>
<td></td>
<td>4) Use information technology to support patient care decisions</td>
<td>*Patient Survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Chart Reviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Procedure Log</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Inpatient Chart Audit</td>
</tr>
<tr>
<td><strong>Medical Knowledge</strong></td>
<td>1) Develop an advanced understanding of disease states</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Demonstrate the skill of reading and interpreting the medical literature</td>
<td>*Presentation abstract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*In-Training Exam</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Web-based assessment tools</td>
</tr>
<tr>
<td><strong>Practice-Based Learning and Improvement</strong></td>
<td>1) Gain competence in bedside teaching</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Journal Club Test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Chart Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*PBL&amp;I Clinic Project</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Inpatient guideline chart review</td>
</tr>
<tr>
<td><strong>Interpersonal and Communication Skills</strong></td>
<td>1) Sustain a therapeutic relationship with patients</td>
<td>*Peer Surveys</td>
</tr>
<tr>
<td></td>
<td>2) Present topics informally and formally to groups of learners</td>
<td>*Nurses Surveys</td>
</tr>
<tr>
<td></td>
<td>3) Develop skills to negotiate</td>
<td>*Patient Surveys</td>
</tr>
<tr>
<td></td>
<td>4) Use effective and appropriate non-verbal communications with patients and colleagues</td>
<td>*Mini CEX</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Grand Rounds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Web-based Communication Module</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*ACP Presentation</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
<td>1) Establish a sense of responsibility for a patient population</td>
<td>*Patient Surveys</td>
</tr>
<tr>
<td></td>
<td>2) Manage and direct a health care team</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>3) Develop conflict management skills</td>
<td>*Nurses Surveys</td>
</tr>
<tr>
<td></td>
<td>4) Work with consultants and other health care teams</td>
<td>*Peer Surveys</td>
</tr>
<tr>
<td><strong>Systems-Based Practice</strong></td>
<td>1) Work with ancillary team members to provide high quality, cost effective health care</td>
<td>*SBL Project</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Management Conference assessment</td>
</tr>
</tbody>
</table>

Minimum requirements for advancement of residents to PGY-3 level of training:
1. Attendance at required conferences unless on approved leave or excused (meet 90% attendance policy).
2. Mastery of basic procedural skills as required by ABIM.
3. Completion of 3 mini CEX's successfully.
4. Satisfactory overall evaluation in all categories.
5. Satisfactory achievement of general competencies.
6. No breach in contractual obligations.
7. No instances of unethical or unprofessional behavior that have not been remediated.
8. Completion of scholarly activity requirements for PGY2 residents (1 ACP abstract presentation or comparable regional presentation, 1 KUSM-W Grand Rounds).
9. Capable of assuming supervisory responsibilities of PGY3 level of training as determined by the Clinical Competency Committee.
PGY-3

The competencies below are expected when those listed for PGY2 above are achieved.

<table>
<thead>
<tr>
<th>ACGME Competencies</th>
<th>Activities</th>
<th>Assessment Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>1) Counsel and education patients and families</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Perform competently the diagnostic and therapeutic procedures essential to the practice of medicine</td>
<td>*Continuing clinic evaluations</td>
</tr>
<tr>
<td></td>
<td>3) Function as an internal medicine consultant</td>
<td>*Mini CEX’s</td>
</tr>
<tr>
<td></td>
<td>4) Integrate clinical common sense and judgment with medical knowledge</td>
<td>*Patient Survey</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>1) Use own knowledge base and other resources for clinical problemsolving</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Develop life-long learning skills to maintain fund of knowledge</td>
<td>*Presentation Abstract</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>1) Analyze own practice for needed improvement</td>
<td>*In-Training Exam</td>
</tr>
<tr>
<td></td>
<td>2) Find and use evidence from scientific studies and clinical guidelines effectively</td>
<td>*Web-based assessment tools</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>1) Relate and communicate with patients and colleagues independently</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td>Professionalism</td>
<td>1) Develop independent professional identity</td>
<td>*Presentation Abstract</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>1) Understand the interaction of practice within the larger health care system</td>
<td>*Rotation Evaluations</td>
</tr>
<tr>
<td></td>
<td>2) Advocate for patients within the health care system</td>
<td>*Nurses Surveys</td>
</tr>
<tr>
<td></td>
<td>3) Use systematic approaches to improve patient care and reduce errors</td>
<td>*Peer Surveys</td>
</tr>
</tbody>
</table>

Minimum requirements for residents in categorical medicine to graduate:
1. Attendance at required conferences unless on approved leave or excused (meet 90% attendance policy).
2. Mastery of basic procedural skills as required by ABIM.
3. Completion of 3 mini CEX’s successfully. Med/Peds residents will complete 3 mini CEX’s each year.
4. Satisfactory overall evaluation in all categories.
5. Satisfactory achievement of general competencies.
6. No breach in contractual obligations.
7. No instances of unethical or unprofessional behavior that have not been remediated
8. Completion of scholarly activity requirements for PGY3 residents (1 ACP abstract presentation or comparable regional presentation, 1 KUSM-W Grand Rounds).
Evaluation of Residents

The resident is evaluated on multiple occasions during the training program based on his/her performance on the wards, in the clinic, at conferences, at morning teaching conference, and other educational functions (see forms in Appendix D).

- A final evaluation is completed at the conclusion of each rotation (general and subspecialty).
- Evaluation of performance in the ambulatory continuity clinic is completed every six months.
- Resident Chart Audits are reviewed in three areas: (1) the General Ward formative evaluation is reviewed by the resident’s Advisor during their 6 month and End of Year evaluation period; (2) the PBL Quality of Care evaluation is reviewed by the General Ward Attending the first and last week of the rotation. Each PGY-2 and PGY-3 resident performs three patient interviews and exams under faculty observation yearly and receives an evaluation of his/her clinical performance (i.e., clinical exam or Mini CEX). Interns will perform and be evaluated on 4 mini clinical exams in the patient care facility of KUSM-W.
- Patient Satisfaction surveys are conducted twice during the year.
- Nursing surveys are conducted twice during the year.
- Peer surveys are conducted during general medicine ward rotations.
- A self-evaluation of clinic charts will be conducted during PGY-2 as part of the Ambulatory Care Rotation.
- Attendance levels at a variety of teaching conferences are used as an evaluative tool on a monthly basis.
- The level and sophistication of resident knowledge acquisition of residents are assessed each year through the required ACP In-Training Examination. (Preliminary residents are not required to take the In-Training Examination.)
- PBL & SBL evaluations
- Journal Club evaluations
- Web-based assessments
- Communication Modules

All residents must achieve the six general competencies required by the Accreditation Council of Graduate Medical Education. By the end of the third year, residents are expected to demonstrate competency in medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. They must acquire the competencies necessary to provide the general medical care expected of every internist qualified to enter the private practice of general internal medicine, subspecialty fellowships, academic careers, or other appropriate clinical pursuits of general internists. All residents will be evaluated using a competency based evaluation system (https://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/InternalMedicineMilestones.pdf) designed to evaluate resident performance. This evaluation system will be used as a tool in reporting the residents’ performance to the ACGME within the 22 ACGME sub-competency reporting milestones within internal medicine. This data will be reported to the ACGME based on the Clinical Competency Committee recommendations twice yearly.

The Clinical Competency Committee meets monthly to review resident performance. At the 6 month review meeting, each applicant’s evaluation portfolio will be examined in detail. This portfolio will include the faculty evaluations from all assigned rotations, the ACP In-Training Examination Score, procedure log, record of scholarly activity, conference attendance record, patient, nursing and peer evaluations, and the continuity clinic evaluation mini CEX’s; SBL and PBL projects. Based on these discussions, decisions will be developed concerning progress in the program, need for and type of remediation, and suitability for promotion or recommendation for dismissal.

All decisions that adversely affect the resident’s timely progress in the program or continuation in the program will be communicated in writing to the resident during a face-to-face meeting. The written notification to the resident will include information regarding filing a grievance. The program observes and follows the WCGME grievance process (see Appendix E).

The program director or designee meets with the resident semi-annually or more often if needed, to review the resident’s progress, rotation evaluations, and recommendations of the Clinical Competency Committee (Summary Evaluation – Appendix D). Residents may meet with their advisor or Associate Program Director to
appeal adverse decisions. Also, the WCGME grievance procedure applies to residents who wish to appeal decisions of the program.

**Resident Remediation Policy**

During any services, if the need for resident remediation is identified, the following protocol is implemented:

1. The program director will be notified of the concern as soon as possible.

2. In coordination with the Director of Internal Medicine Education of the hospital service and the attending assigned to the service, plans will be made to alter the patient load for the remainder of the rotation. Patient care quality will be preserved.

3. A meeting will be arranged with the resident in need of remediation and a formal written remediation plan will be developed. This meeting will involve the program director, the hospital’s DIME, and/or the ward attending.

4. It is desirable for the resident to remain on the service unless concerns about the safety of patients or other substantial mitigating factors exist that suggest a change of rotation is the optimal course of action.

5. The resident will be re-assessed at the conclusion of the rotation to determine if further remediation is necessary or to develop an extended remediation plan.
Advisor Program

Each resident is assigned a faculty advisor upon entering the program. The following guidelines provide the structure for the mentor program.

**Objectives**
- Serve as a consistent and regular advisor to the resident. An advisor is defined as a guide, coach, or facilitator. In this role, you are not an evaluator.
- Obtain feedback on their learning experiences/rotations. Reflect on what worked well and what did not.
- Determine if psychological, social, or emotional barriers to educational objectives exist. Suggest methods to reduce or eliminate barriers.
- Identify study patterns and assist them in developing an effective study plan, especially if the resident has knowledge deficits.
- Determine their long-term goals and assist with developing a plan to achieve them. Assist with goal setting if necessary.

**Basic Learning Principles**
- Adults learn what they are motivated to learn. They learn to solve perceived problems. Learning should be applicable to their work or responsibilities.
- Adults are practical and goal-oriented. They focus on things most useful to them.
- Adult teaching is grounded in the learners’ experiences. New information and concepts build upon this foundation.
- Adults learn best in a supportive environment. They want guidance. They learn when they are psychologically and physically comforted.

**Advisor Responsibilities**
- Meet with assigned PGY1 residents at least monthly (e.g., a few minutes to an hour). If necessary, a phone meeting is acceptable. The objective is communication in a supportive, non-threatening manner.
- Meet with assigned PGY2-4 residents at regular intervals (at least quarterly) unless educational difficulties necessitate more frequent meetings.
- Set realistic expectations with the resident for the mentoring relationship.
- Follow-up on any previous suggestions, assignments, problems, or information promised.

**Advisor Assignments**
- PGY-1 residents will be assigned to faculty mentors. If successful, the faculty advisor and resident will continue the mentoring relationship beyond the first year.
- If the mentor relationship does not work, either the faculty mentor or resident may request a change by notifying the Program Director or his associates.

*Six month and end of year evaluations will be completed by the Program Director and Associate Program Director.*
Attending Faculty Teaching Expectations

Attending faculty confirm and augment key historical facts and physical findings elicited by the resident, assess the resident's understanding and synthesis through case presentations and discussions, and evaluate and substantiate the resident's demonstration of appropriate interpersonal skills, clinical reasoning, decision-making, cost awareness, risk-avoidance, diagnostic abilities and technical proficiency. Emphasis is on bedside teaching. Patient notes are reviewed routinely to assess clinical judgment, medical knowledge, and communication skills. Faculty observes and evaluates humanistic qualities, professionalism, and procedural skills of each resident. Faculty also conduct at least 4.5 hours of teaching rounds weekly, attend program conferences as able, present conferences on request and accept additional teaching responsibilities as requested by the program director.

Documentation and Feedback
Verbal and written feedback is fundamental to the educational process. During and at the end of each rotation, attendings provide each resident with a critical appraisal of clinical competence by recognizing both the strengths and weakness in performance. Each component listed on evaluations summaries (see Appendix D) is evaluated using the following guidelines:

- "Unable to Assess"
- "Resident cannot perform this skill even with assistance" Is the level expected for most students.
- "Resident can perform this skill under close direct supervision of a senior resident or attending" Is the level at which most interns begin.
- "Resident can perform this skill under indirect supervision of the attending" Is where most residents practice inside the scope of residency (with the attending supervising their work).
- "Resident is ready for independent unsupervised practice" Is the level at which a resident is ready to graduate and practice independently.
- "Aspirational" Is a level that all physicians strive for, but may not reach over the course of their career.

Most residents consistently perform at least at the “resident can perform this skill under indirect supervision of the attending” throughout their training experience.

Facility are responsible for submitting completed evaluation forms to the residency office. All evaluations are required and necessary to determine a global assessment of resident performance.

Resident Service Evaluations
Feedback from residents about the organization and conduct of each service as well as the teaching and supervision provided by the faculty is vital. Constructive criticism or even praise is welcome at any time, but the department expects written comments from each resident at the completion of each rotation. This information is used by the Program Director to improve rotations and to provide suggestions to faculty to enhance learning. The actual form is not distributed to the faculty. There should be no illusions about retribution as a result of such feedback. Resident feedback, however, should be constructive, tactful, and professional.

Teaching Ratio
For each rotation or major clinical assignment, the teaching ratio must not exceed a total of 8 residents and students (excluding subspecialty residents in special care units) to one teaching attending.
Resident Responsibilities, Program & Accreditation Rules

Resident responsibilities for patients vary depending on the level of training, experience, skills and abilities of the trainees, as well as faculty expectations. Specific responsibilities and expectations should be reviewed with the responsible faculty at the beginning of each assignment and whenever uncertainties or problems develop. The resident should always ask for clarification of responsibilities; delay will invite miscommunication and impair patient care.

Excessive reliance on residents to meet the service needs of the training sites is not acceptable to the educational purpose of residency. To this effect:

- Residents must not be required to provide intravenous, phlebotomy, or messenger/transporter services routinely.
- Service responsibilities must be limited to patients for whom the resident has been assigned ongoing diagnostic and therapeutic responsibility.
- The admission and continuing care of patients by residents must be limited to those on the teaching service.

**Duty Hours**

Based on ACGME FAQ for Common Program Requirements updated on 6/18/2014

**KU Wichita Internal Medicine Residency Program Duty Hour Policy:**

All residents are limited to no more than 80 hours of duty within a work week. For any week where a resident expects that they may exceed the 80 hour limit, they must discuss with the Program Director for prior approval so that an action plan can be developed to ensure that their average duty hours for the current rotation remain in compliance with the ACGME requirement of 80 hours per week average for a rotation.

Duty hour periods for PGY1 residents must not exceed 16 hours and, for PGY2 residents and above, must not exceed 24 hours of continuous duty. All residents are expected to have 10 hours off prior to returning to duty and must have a minimum of 8 hours free from duty under all circumstances. In the event that a resident chooses to engage in a patient care activity that is of exceptional educational value or critical to the wellbeing of the patient under the resident's care, the resident may stay beyond this scheduled duty period but must report this violation of the 8 hour duty-free period requirement to the Program Director. Circumstances that result in residents having a violation in the "must have 8 hours" free from duty rule should be limited to upper level (PGY2 and above) residents.

Additionally, time spent completing medical records, whether in the hospital or from home (or any other location), will be counted towards the 80 hour weekly limit.

**Days Off:**

All residents must have one day off per week on a rotation.

For example, if the resident is on a:
One week rotation, he/she must have at least one day off; Two week rotation, he/she must have at least two days off;
Three week rotation, he/she must have at least three days off; Four week rotation, he/she must have at least four days off.

For these purposes, all rotation hours and days off will be calculated using Monday as the starting day of the rotation period and Sunday as the ending day of the rotation period.

Days spent on vacation leave are not counted towards these days off. This applies to weekdays that have been approved for vacation leave.

For example, a resident is on a four week rotation and takes 5 days of vacation leave during the rotation. This resident would need to have at least three days off averaged per week during the remaining three weeks of rotation time.

**Inpatient Requirements**

PGY-1 residents on inpatient medicine rotations must not be assigned more than five new patients per admitting day. An additional two patients may be assigned if they are in-house transfers from the other services or the call team. No more than eight new patients may be assigned in a 48-hour period. A first-year resident must not be responsible for the ongoing care of more than 10 patients or fewer if the educational needs of the resident dictate.
When supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and 4 transfer patients per admitting day or more than 16 new patients in a 48-hour period. When supervising only one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients. When supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients.

In situations in which patient volume reaches 10 patients for each PGY-1 and/or 20 patients if supervising 2 interns, 14 patients if supervising 1 intern, the "Excessive Census Plan" will be implemented immediately (see Appendix F).

**Back-up Plan**

At times, it may be necessary to shift residents to maintain the best learning environment on specific rotations. If a resident will be absent from a General Medicine Ward or ICU service for an extended time period, the back-up plan may be utilized. Another resident (the back-up resident) will be shifted to replace the absent colleague. The shift may be for a few days or for the remainder of the rotation. Residents will be notified in advance that they are one of the designated back-ups.

In addition, the back-up plan will be utilized for the on-call team. If an on-call team (consisting of a PGY-1 and PGY-2 or PGY-3) has more than 10 admissions or 4 transfers during the “on-call” period from 8am to 8am on a weekday, or has more than 10 admissions and consults during the “on-call” period from 8am to 8am on a weekend, then the senior resident should notify the attending on call (5 admits and 2 transfers for the intern, 10 admits and 4 transfers total to supervising resident). Occasionally, there may be circumstances in which a fewer number of patients are admitted, but the call team determines that patient care may be compromised due to excessive time commitments necessary to provide care. If this happens, the senior resident also should notify the attending on call. In any of these circumstances, the senior resident and the attending will decide together if it is best for patient care to call in the back-up resident. A chief resident should be notified, the back-up call schedule should be accessed, and an additional senior resident from that list should be notified to come in to the hospital to assist with patient care during the call period.

**Cardiology Rotations**

The free-standing heart hospitals are not approved training sites for the residency program. Residents may work with attendings at their outpatient, ambulatory office settings, but only at Via Christi Health, Wesley Medical Center, or the VA for inpatient settings.

**Ambulatory Medicine Requirements**

A minimum of one-third of residency training must be in the ambulatory care setting. Residents must attend a minimum of 130 distinct half-day continuity clinic sessions during the 36 months of training. The continuing patient-care experience should not be interrupted by more than one month, excluding vacation.

**Patient Care Requirements**

All residents are expected to be available for both outpatients and assigned inpatients at all times. They will be available for calls from their patients, hospital staff, attending, consultants or clinic personnel at all times through the paging system unless they are checked out to another resident.

Residents will perform and record a history and physical, formulate a problem list, construct a differential diagnosis, and outline a diagnostic and therapeutic treatment plan on each patient. The plan will be carried out through completion of all orders on the assigned patients; other physicians should not write orders except in emergency situations or in situations which the orders pertain to very specialized subspeciality issues requiring consultant expertise (e.g.-dialysis orders). In these instances, the resident will be notified of the orders. The resident will re-evaluate the assigned patients at least daily and more frequently if necessary. Critical care patients must be seen at least twice daily. A daily note in the problem-oriented medical record format will be recorded and should update and reflect the resident’s thought process about the differential diagnosis and plans. If the student constructs the progress note, the resident will amend the note critically as needed, and then co-sign. The resident will review his/her findings with the senior resident and/or faculty at least daily and more
frequently if necessary. The responsible faculty ultimately must support all treatment and diagnostic plans. The resident must complete the patient evaluation in a timely and efficient manner so that treatment plans can be reviewed and executed early in the workday.

Third-year residents supervising the general medicine ward services will be available at all times to their interns and faculty for discussion or consultation regarding patients. Third-year residents supervising the inpatient services will instruct the first-year residents to call them if they have any concerns about a patient's status or other problems. Third-year supervising residents will be responsible to assist the interns including coming back to the hospital, if necessary, to assist the interns in assessment and care of patients who have had a change of status.

Any residents who are on vacation, absent, moonlighting, or have other responsibilities that impede their ability to assist the intern or return to the hospital at any time will make arrangements for another appropriate resident to assume those responsibilities and expectations. The senior resident must see each patient daily and must write a progress note on the first day of admission if the patient was admitted before midnight. The senior resident is responsible to the assigned faculty attending and should review the patients and junior trainee’s performance at least daily with the faculty. Lastly, the senior resident will act as a liaison between the ward team and ancillary health care providers.

Faculty and senior residents will monitor the patient volume on the services. In situations in which patient volume reaches 10 patients for each PGY-1 and/or 20 patients if supervising 2 interns, 14 patients if supervising 1 intern, the "Excessive Census Plan" will be implemented immediately (see Appendix F).

### Procedures

The majority of procedures will be completed by the PGY-1 resident under the supervision of faculty or residents who have demonstrated proficiency. The faculty or senior resident may elect to perform the procedure personally due to patient considerations or to demonstrate proper technique. Consulting service residents should not perform procedures on another resident’s patient unless authorized by the patient’s attending physician; even then, the primary care resident should be involved in at least an observational or educational role.

### Death Pronouncements

If an intern is admitting a patient or participating in an emergency, a delay of one hour for making a death pronouncement is acceptable and the intern should inform the nursing staff. If the delay will be greater than one hour, the senior resident should relieve the intern making the pronouncement. Do not leave codes to make pronouncements unless you are specifically authorized to do so by the senior resident in charge of the code. Senior residents should cover intern activities while interns make pronouncements. Time response should be less than 30 minutes.

### Rounds

The resident will be prepared to discuss his/her assigned patients during rounds. Each patient’s chart, new lab data, x-rays, and other pertinent information should be examined and a treatment plan formulated before rounds. Progress notes and orders should be completed before rounds.

### Discharge Summary

The resident will formulate and arrange discharge plans for each assigned patient, including adequate follow-up or transfer. At the time of discharge or transfer, the resident will complete the discharge summary. The summary should briefly describe the reasons for admission, the pertinent findings, the hospital course, and the status and plans at discharge. Rarely should the discharge summary be longer than 1 - 1½ pages in length. It should be dictated within 24 hours of discharge.

### Schedule Changes

Requests for schedule changes by residents must be submitted to the Internal Medicine Residency Department at least 30 days prior to the rotation affected. Requests submitted after 30 days will not be approved.
**Chart Work**
Chart work must be completed daily. History and physical must be written (or dictated) on the day of admission and discharge summaries on the day of dismissal. All notes and signatures should be completed daily. Compulsive daily chart work is mandatory. Incomplete chart work should be kept to an absolute minimum; excessive incomplete chart work will not be tolerated. The WCGME Medical Record Completion Policy specifies penalties for incomplete charts.

**Components of Problem-Oriented Medical Record**
1. Initial Data Base (i.e., History & Physical)
2. Assessment
3. Plans
4. Daily progress note by numbered problems using SOAP format
5. Daily update of assessment/plan

**Senior Level Responsibilities**
Senior level resident responsibility varies with the type of assignment, but generally includes increased supervisory, teaching, patient-care, and leadership responsibilities. On many of the subspecialty electives, the resident will act as a consultant. Other services combine consultative and primary care responsibilities. The resident’s responsibilities and rotation objectives must be reviewed with the attending faculty on or before the first day of the service.

The senior resident on general medicine ward services is directly responsible for the care of the assigned patients and conduct of the service. The resident will review the work of the students and junior residents daily and will provide guidance or even direct instruction if necessary.

In addition to patient care activities, the senior resident should coordinate, lead, and assign educational activities on the service (e.g., conferences, reading topics, report topics, conference assignments, etc.). The senior resident will assign patients to the medical student and will oversee the activities of the student.

**Handoff Procedure – Daily Handoff and Change of Service Handoff**
- See Appendix J

**VA Critical Care Rotation Responsibilities – Calls by Nursing Staff**
Calls by the nursing staff regarding a patient in the ICU should be addressed to the Junior ICU resident and in his/her absence, to the senior ICU resident. If a patient is deteriorating/needs assessment as soon as possible, then the in-house intern should be called. He and the ICU junior/senior team should manage the patients care in coordination with the urgent care physician or ICU attending if necessary. It is expected that the ICU senior should care for and see critically ill patients that have decompensated after regular hours if requested by the junior.

**Responsibility to Students**
Internal medicine residents are integral in the education of medical students. The resident should be familiar with the responsibilities and expectations of the students and should hold them accountable. The resident often is viewed as the focus of teaching on the service and is expected to provide considerable teaching and guidance to the student. If a major change occurs in a patient or a procedure is performed, the student should be notified. Residents should demonstrate physical findings, skills useful in eliciting the history, or other skills useful to the student.
The Obligatory Clerkship: Guidelines For Residents

- The main point of this clerkship for students is:
  A) the collection and verification of the patient’s database;
  B) reasonable interpretation of the data; and
  C) preliminary understanding of the care of the patient.

- The students need 12 new patient assignments for the eight weeks or an average of 2 new patients every week. If there are insufficient admissions on the assigned service to achieve this requirement, the resident should seek additional patients on other services. These “outside” assignments are to be accomplished with the knowledge of the responsible faculty and the permission of the resident and attending staff on the other services.

- Brief critical case summaries are required. The attending faculty will review, evaluate, and assign a grade to the summary.

- The student must complete new patient work-ups and critical case summaries, and attend the various conferences, attending rounds, and professor rounds. The resident must have an understanding of the students’ schedules and their additional commitments to be a fair and effective teacher.

- The student should be made aware of the general obligations of the attending staff, the residents, and the entire service and/or panel; in practical terms, the student must be responsive to the needs of the service primarily through the resident (and/or attending staff) whenever deemed necessary.

- The students should be called in whenever a new patient is admitted or if special events occur to their assigned patients, regardless of the hour. The students should be involved in all activities and procedures regarding their assigned patients. Such events should be anticipated and communicated clearly to the student in advance.

- Special attention is directed to information obtained by the student: the complete history and physical examination (and in some instances, routine laboratory work), the development of a problem list and daily progress notes that are problem-oriented. Students will be held accountable for every relevant item in their patients’ charts.

- The students will not be expected to perform pelvic or rectal examinations on female patients; these important aspects of the physical examination may be included in appropriate and selected patients, but only when properly supervised. Rectal examinations on male patients should be done by the students if indicated, unless the resident or faculty specifically request that the examination not be done.

- The resident should set aside at least one time a week for chart reviews with the student. At this time, the database and the clinical course of assigned patients can be explained and discussed. The progress of plans of investigation, management, and education can be evaluated critically, and more importantly, the student’s work can be reviewed directly.

- The student is expected to go on teaching rounds with the attending staff and the resident. It also is appropriate for the resident and student to have separate bedside teaching sessions periodically. It is reasonable and necessary to achieve a mutually agreeable schedule for all activities (e.g., rounds and procedures). It is the resident’s responsibility to arrange their timing; the student will honor the schedule by being prompt and reliable. The student’s other obligations for conferences and meetings take first priority, however a hospital noon conference or Grand Rounds can be missed for an important learning experience at the hospital.

- The students are encouraged to become a part of the patient care team, but while on the obligatory clerkship they are not responsible for execution or implementation of the care.

- The residents will be asked to help in the assessment of the student’s performance according to the above guidelines.

The resident should communicate any serious problems the assigned student may have promptly to the responsible faculty. Emotional, family, health, marital, legal, financial, or other personal problems may affect educational performance adversely and should be addressed with the assistance of the faculty and appropriate administrative support staff.
Supervisory Reporting Process – interns, seniors, faculty

**Ward Services**
On the general medicine ward services, the supervising faculty is responsible for all patient care activities. The senior resident is responsible for communicating directly with the supervising faculty on a daily basis and more frequently, if necessary. Any major change in patient status or any major new findings will be reported to the attending faculty by the senior resident. The senior resident will ensure that the faculty is informed of each patient's status during rounds, or immediately if the situation indicates. When the senior resident is on vacation, the first-year residents will report directly to the attending faculty. The attending faculty is always available by pager for acute emergent problems.

First-year residents on the general medicine ward teams are to report directly to the senior resident. They will keep the senior resident informed of all major changes in patient care status, new important laboratory information, or other important patient care data. In those cases in which the senior resident is not available, interns are to report directly to the attending physician. In any situation in which the first-year residents are not able to reach the senior resident or feel there are major patient concerns incompletely addressed, they will contact the attending faculty directly for consultation. When the 1st year resident is taking sick leave, on vacation, post call or is otherwise unavailable, the supervising senior resident will assume care of her/his patients. The senior resident and 1st year resident should not be off duty simultaneously.

**Sub-Specialty Services**
On services in which the resident, regardless of level, works directly with faculty, the resident is to report directly to the attending faculty on a daily or, if necessary, more frequent basis. All information of importance about the patient will be reported daily on rounds. Any changes in patient status that require immediate action will be reviewed with the attending faculty who will always be available by phone or pager.

**Special Cases**
Every patient encounter involving residents in this program will have a supervising faculty responsible for the patient's welfare. Therefore, residents must use good judgment in deciding when supervising faculty should be notified of changes in patient status. In any case in which the attending faculty is unavailable, the resident should notify the responsible Director of Internal Medicine Education at the teaching site and, if necessary, they should contact the Program Director for any unresolved patient care issues.

In cases in which residents evaluate patients for acute emergent problems in the hospital who are not on the teaching service, the physician of record must be contacted to discuss the care of the patient and to make arrangements for transfer of ongoing care to the attending of record. In cases in which the resident is unable to contact the physician of record or finds the disposition unacceptable, the resident should contact the Director of Internal Medicine Education at that hospital for further deliberation about the appropriate physician(s) to provide on-going care of the patient. Residents are not responsible for the on-going care of patients which are not on teaching services.

**Hospital Call**
Each hospital has On-Call / Night Float responsibilities and duties that vary depending on the level of training and training site. The Director of Internal Medicine Education at each hospital will inform residents of the duties. On Call hours and responsibilities are listed on page 22.

Residents on-call are to notify the responsible resident for any patient care issues that occur on hospitalized patients. They are also to clarify with the responsible resident who will notify the attending for any important or major changes in patient status. In all cases in which important patient issues arise at night or on weekends while the on-call team is covering the hospitalized patients, the responsible faculty must be informed. In most cases, it is the responsibility of the senior resident on-call to ensure that the responsible faculty is notified. The on call resident must communicate directly to the responsible physicians and must never communicate solely through an intermediator. The on call resident should determine whether the responsible patient care team
should report to the hospital to provide ongoing care of unstable patients or whether the on-call team will continue to manage the patient through the night.

Junior residents always will keep the senior resident who is on-call informed of any important changes in patient care status. Patients requiring admission from the emergency room will be seen by the senior resident who will notify the junior resident of the patient's admission. All patients seen in the emergency room by senior residents will be discussed with the responsible faculty member who is always available by phone or pager. The On-Call / Night Float team will manage new admissions until care is transferred to the responsible team via direct communication.

Requests for relief from call responsibilities should be made before the call schedule is completed. Residents must notify the Internal Medicine residency office to request blocking particular days from call.

PGY-1 residents may request 1 weekend free from call (Friday evening through Sunday night). PGY-2, PGY-3, and PGY-4 residents may request 2 weekends free from call (Friday evening through Sunday night). Additional requests beyond the weekends listed above will be honored only when doing so will not place undue burdens on other residents. If a week or more of vacation is scheduled during a given month, call duties will be decreased by one night during the month. Once the call schedule is issued, it is the responsibility of individual residents to work with his/her colleagues to switch call dates if necessary.

The call schedule will be prepared by the chief residents and distributed at least 15 days before the first day of the call month. Any changes in the call system will be communicated promptly and clearly to the departmental residency office as well as to the DIME at the hospital in which the call is to be taken. If illness or other personal situations develop that precludes someone from completing their call assignment, the resident is responsible for notifying the chief resident who will arrange a substitution. By using the designated back-up schedule, the chief resident will notify another resident who will assume the call responsibilities for the resident who is indisposed.

**Switching Call/NF / Splitting Calls:**
Residents splitting up 24 hour call leads to excessive handoffs and greater chance of inadequate communication. Call duration is set by the program and no resident shall split a call or change the duration of a call. No alterations can be made to the night float schedule, which includes trading night float nights with other call nights or switching residents' night float weeks during the month. If residents must trade calls, they must trade a full call for a full call (Intern call M-F 5-9pm and Sat-Sun 7a-9p; Senior call M-F 5p-7a and Sat-Sun 7a-7a) and cannot break the call into parts. If a resident must leave a call for unseen circumstances, they must notify the attending on call and arrangements must be made for coverage prior to the resident leaving the hospital.
On Call Hours and Responsibilities

Via Christi Health (VC):

PGY1
- Monday – Friday, 5:00pm – 7:00am, Night Float (5 nights)
- Saturday and Sunday, 7:00am – 9:00pm, Call Pool (14 hours)

SENIORS
- Monday – Friday, 5:00pm – 7:00am, Night Float (14 hours)
- Saturday and Sunday, 7:00am – 7:00am, Call Pool (24 hours)
- It is highly recommended that the resident is able to obtain some sleep between 10:00 pm – 7:00 am.
- No pronouncements, no first line assessment of falls or strokes.

Wesley Medical Center (WMC):

PGY1
- Monday – Friday, 5:00pm – 9:00pm, Call Pool (4 hours)
- Saturday – Sunday, 7:00am – 9:00pm, Call Pool (14 hours)

SENIORS
- Monday – Friday, 5:00pm – 7:00am, Night Float (14 hours)
- Saturday and Sunday 7:00am – 7:00am, Call Pool (24 hours)
- No pronouncements, no first line assessments of falls or strokes.

VA Medical Center (VAMC):

PGY1
- Monday – Friday, 5:00pm – 9:00pm, Call Pool (4 hours)
- Saturday – Sunday, 7:00am – 9:00pm, Call Pool (14 hours)

SENIORS
- Senior call – available to assist PGY1, 5:00 – 9:00pm on weekdays and from 7:00 am – 9:00 pm on weekends. Seniors must be in house until 7pm.
- VA staff physicians (nocturnist) responsible for admissions 9:00 pm to 7:00 am

===================================================================

Senior duties for Wesley and Via Christi:
- Supervise PGY1 residents
- Lead code blues
- After PGY1 leaves, admit patients as noted above
- Does not evaluate falls
- Does not do pronouncements
On-Call Responsibilities - Via Christi Health

Description
The on call team consists of one senior resident and one first year resident. St. Francis on call rooms are on the 2nd floor between elevators A&D. Call hours are as noted on the “On Call Hours & Responsibilities” page.

Senior resident responsibilities
1. Initial contact person for teaching panel members admitting patients to the teaching service.
2. Available for evaluation of patients who may be potential admissions to the teaching services in the E.D. at the request of teaching panel members or E.D. physicians.
3. Available for emergency consultations on teaching service patients.
4. Supervisor and teacher for junior residents and students.
5. Senior resident will see new patients from the night before prior to morning rounds. Patient load will then be distributed evenly to the junior residents after rounds. It is up to the senior’s discretion as to when this handoff to the junior will occur. Reasonable options include directly after rounds, at the end of the workday, or the following morning.
6. Code blue responsibilities as noted below.
7. Census cards to be completed by all residents and turned in to the residency secretary at the end of every week while on Med 1, Med 2, or NF. Census cards will be distributed in your mailbox in room 2158 at beginning of rotation. The combination is 1,3,1,3.
8. Weekly logging of work hours on New Innovations. (www.new-innov.com)

Junior resident responsibilities
1. Evaluates and cares for admissions to the teaching service.
2. Additional contact person for students.
3. Code blue responsibilities as listed below.
4. Census cards to be completed by all residents and turned in to residency secretary at end of every week while on Med 1, Med 2, or NF. Time reports will be distributed in your mailbox in room 2158 at beginning of rotation.
5. Weekly logging of work hours on New Innovations. (www.new-innov.com)

Code Blue responsibilities
By a joint decision with the medical staff, Via Christi Regional Medical Center and KUSM-W, the internal medicine on-call team is the physician component of the code blue team at VIA CHRISTI HEALTH - ST. FRANCIS. The responsibilities of each of the on-call residents in this situation are as follows:

A. Senior Resident
1. Is responsible for coordinating the resuscitation effort.
2. Will be responsible for giving all orders and: making all decisions unless the attending physician of the patient or his/her designate is present.
3. May perform certain procedures such as intubation or establishment of vascular access as necessary.

B. Junior Resident
1. Is responsible for establishment of adequate CPR.
2. Will do necessary procedures to establish vascular access, airway, etc., under the supervision of the senior resident.
3. Is responsible for communication from the code team to outside parties (e.g. other physicians.)
4. Other duties as required by the senior resident.

Rapid response responsibilities
Senior and junior resident will not be obliged to respond to rapid response pages unless the rapid response call specifies that a physician is requested. For now, this will be a nurse-led response in all other situations.
On-Call Responsibilities - Wesley Medical Center

Description
The on call team consists of one senior resident and one first year resident. Wesley on call rooms are on the 4th floor, building 1. Call hours are as noted on the “On Call Hours & Responsibilities” page.

Senior resident responsibilities
1. Initial contact person for teaching panel members admitting patients to the teaching service.
2. Available for evaluation of patients who may be potential admissions to the teaching services in the E.D. at the request of teaching panel members or E.D. physicians.
3. Available for emergency consultations on teaching service patients.
4. Supervisor and teacher for junior residents and students.
5. Senior (3rd year) resident, on the Med 1 team, will see new patients from the night before prior to morning rounds. Patient load will then be distributed evenly to the junior residents after rounds. It is up to the senior’s discretion as to when this handoff to the junior will occur. Reasonable options include directly after rounds, at the end of the workday, or the following morning.
6. When the Med 1 team senior is off (i.e. two PGY1’s remain for weekend coverage), the PGY2 or PGY3 senior assigned to call on Saturdays and Sundays will be obliged to see new patients admitted the night previously and participate in morning rounds to aid in transition of care. They will then handoff the patients to the juniors immediately after rounds and can be available for admissions or interns’ questions on inpatients.
7. Code blue responsibilities as noted below.
8. Census cards to be completed by all residents and turned in to the residency secretary at the end of every week while on Med 1 or NF. Census cards will be distributed in your mailbox in the medical education office.

Junior resident responsibilities
1. Evaluates and cares for admissions to the teaching service.
2. Additional contact person for students.
3. Code blue responsibilities as listed below.
4. Census cards to be completed by all residents and turned in to the residency secretary at the end of the Wesley rotation. Time reports will be distributed in your mailbox in the medical education office, suite102 at the beginning of rotation.
5. Weekly logging of work hours on New Innovations. (www.new-innov.com)

Code Blue responsibilities
By a joint decision with the medical staff, Wesley Medical Center and KUSM-W, the Internal Medicine on-call team is the physician component of the code blue team at Wesley between 7pm and 7am. The senior and junior residents are also required to respond to codes between 7am and 7pm in order to offer assistance to the Family Medicine team, who will be the primary responders during that time. The responsibilities of each of the on-call residents in this situation are as follows:

A. Senior Resident
1. Is responsible for coordinating the resuscitation effort.
2. Will be responsible for giving all orders and: making all decisions unless the attending physician of the patient or his/her designate is present.
3. May perform certain procedures such as intubation or establishment of vascular access as necessary.

B. Junior Resident
1. Is responsible for establishment of adequate. CPR.
2. Will do necessary procedures to establish vascular access, airway, etc., under the supervision of the senior resident.
3. Is responsible for communication from the code team to outside parties (e.g. other physicians.)
4. Other duties as required by the senior resident.
Rapid response responsibilities

Senior and junior residents will be obliged to respond to rapid response pages as well. However, the Internal Medicine on-call team will be the primary responders between 7pm-7am. The senior and junior residents are also required to respond to rapid responses between 7am and 7pm in order to offer assistance to the Family Medicine team, who will be the primary responders during that time.
On-Call Responsibilities - VA Medical Center

Description
The on-call team consists of a first year resident who is supervised by a senior resident and/or an attending physician with an urgent care physician available for emergencies. Call hours are as noted on the “On Call Hours & Responsibilities” page.

Meals are available in the refrigerator in the team room on the third floor. The kitchen will prepare a tray for residents at their request.

Senior ward resident responsibilities:
1. The Senior Resident is available as a teacher and supervisor for the Junior Residents and Students on their ward rotations.
2. Directly supervises admissions and patient care on the wards from 7:00am – 5:00pm weekdays. Seniors will also be expected to receive check-out on all ward patients admitted between 5:00pm-7:00am and see those patients assigned to them prior to morning rounds.
3. Carries the Code Pager and responds to codes 7:00am – 5:00pm weekdays.
4. The on-call senior must be in house until 7:00pm on weekdays and from 7:00am-7:00pm on weekends. They must be available to return to the hospital if needed until 9:00pm. Duties include getting checkout on all ward and ICU admissions seen between 5:00pm – 9:00pm and being available in-house for any emergencies, difficult admissions, procedures, or other patient care duties on patients for which the Junior Resident needs assistance.
5. The Senior is expected to call the attending physician with any patient situations in which he or she is not comfortable or if there are any questions regarding patient care.

Senior ICU resident responsibilities:
1. The Senior Resident is available as a teacher and supervisor for the Junior Resident and Students on their ICU rotations.
2. On weekdays, directly supervises admissions and patient care in the ICU from 7:00am – 5:00pm. Seniors will also be expected to receive check-out on all ICU patients admitted between 5:00pm-7:00am and see those patients prior to morning rounds.
3. The on-call senior must be in house until 7:00pm on weekdays and from 7:00am-7:00pm on weekends. They must be available to return to the hospital if needed until 9:00pm. Duties include getting checkout on all ward and ICU admissions seen between 5:00pm – 9:00pm and being available in-house for any emergencies, difficult admissions, procedures, or other patient care duties on patients for which the Junior Resident needs assistance (REWORDED ALL OF THIS).
4. The Senior is expected to call the attending physician with any patient situations in which he or she is not comfortable or if there are any questions regarding patient care

Intern/Junior resident responsibilities:
1. Evaluation/management of admissions to the Medical Service and the ICU.
2. Code Blue: Residents are expected to respond immediately to all codes.
3. The Junior Resident on call is supervised by a Senior Resident and/or attending physician on call as described above from 5:00pm to 9:00pm on weekdays, and 7:00am to 9:00pm on weekends and holidays and by their faculty rotation attending and their Senior resident from 7:00am to 5:00pm weekdays. All admissions must be discussed with a supervising Senior Resident and/or attending physician. The Urgent Care physician in-house is available for any patient emergencies in which a delay for the senior resident or attending physician to get to the hospital would jeopardize patient care. The Junior Resident should contact the supervising Senior Resident or attending regarding problems with previously admitted patients on the teaching service.

Attending physician responsibilities:
1. The attending physicians on wards will supervise ward admissions as necessary from 7:00am – 5:00pm weekdays. The ICU attending physician will supervise ICU admission as necessary from 7:00am – 5:00pm weekdays.
2. Each of the three monthly attendings (2 ward attendings and 1 ICU attending) will take at-home call shared with each of the 3 Senior Residents. ICU attendings will only take at-home call for ICU admissions and ward attendings will take at-home call only on ward admissions, so that there are two attendings on call per night. Duties include getting checkout on admissions from 5:00pm – 9:00 pm weekdays and 7:00am – 9:00 pm weekends and holidays, and presenting to the hospital for any emergencies, difficult admissions, procedures, or other patient care duties on patients for which the Junior Resident needs direct supervision in addition to what is provided by the Senior Resident.
3. The attending physician should also be available for calls on nights when a Senior Resident is supervising, so that if patients situations/questions arise, the Senior Resident is able to contact a supervising physician.

Code Blue responsibilities:
1. The code blues from 7:00am – 5:00pm weekdays will be run and supervised by the Senior ward resident. Codes from 5:00pm – 9:00pm weekdays and 7:00am – 9:00pm weekends and holidays will be run and supervised by the senior resident. The Urgent Care physician is available between 7pm-9pm if the senior is no longer in house.
2. The Junior Resident will attend and participate in all codes 7:00am – 9:00pm weekdays and 7:00am – 9:00pm weekends and holidays (when on call).
Wesley Medical Center-Night Float/Work Flow

**Night Float**

2nd year Internal Medicine residents will work a total of 4-5 weeks of nights, with 1-2 consecutive weeks of nights at Wesley Medical Center referred to as Night Float (NF). NF is responsible for all overnight admissions as well as supervision of the On-Call intern and medical student. The NF resident will also carry the code pager and respond to codes and rapid responses as delineated in Code blue and Rapid Response responsibilities section.

NF shifts will begin at 5 pm and end at 7 am the following morning. **Handoff procedure:** Before the end of their shift, the NF resident needs to do a face-to-face checkout. **This Face-to-face check-out is mandatory, involves hand-off of the code pagers, and must occur with the senior resident that is assuming care of overnight admissions.**

NF will be off Saturday night and Sunday night during their NF Block (these will be the only days off while on service) and will be responsible for NF duties beginning Monday night at 5 pm (Mon. 5 pm – Tues. 7 am) and ending with the Friday night shift (Fri. 5 pm – Sat. 7 am).

**Weekend Call Duties**

-2nd or 3rd year residents assigned from the On-Call pool of residents will be responsible for weekend call (admissions) per the following schedule:

1) Saturday morning 7 am – Sunday morning 7 am
2) Sunday morning 7 am – Monday morning 7 am.

Overnight admissions will need to be handed off the following morning to the Med 1 senior or to the incoming on-call senior (if Med 1 senior is off). **Handoff procedure:** Before the end of their shift, the on-call senior resident needs to do a face-to-face checkout. **This Face-to-face check-out is mandatory with daytime senior on the weekend assuming care of overnight admissions.**

-1st year residents will be assigned to call per the On-Call schedule. Weekday call (Mon-Fri) will be 5:00pm – 9:00pm. Weekend call (Sat-Sun) will be 7:00am – 9:00pm.

**Patient Caps**

Service will be closed to unassigned patients (Soft Cap) at 18-20 patients per attending discretion; if Senior Resident (3rd year) is off, Cap will be 14-16 patients per attending discretion.

**Weekday Rounds and Admissions**

The Med 1 daytime team will be comprised of one PGY 3 resident and two (PGY1) junior residents. Weekday rounds with the daytime team of residents will begin around 9am with discharge planning rounds. Admissions during the day on weekdays will be assigned to the juniors by the 3rd year residents. Overnight admissions will be assigned by the 3rd year resident during rounds just prior to the presentation of that specific patient. **All Residents must write a note assuming care of the patient within 24 hours of admission.**

**Weekend Rounds and Admissions**

Weekend rounds with the daytime team of residents will begin at the discretion of the attending. Admissions during the day on weekends will be covered by the on-call team. Overnight admissions will need to be assigned to the juniors during rounds just prior to the presentation of the specific patient. Assignment will be done by the 3rd year Med 1 resident or by the on-call senior if the Med 1 resident is off. **All Residents must write a note assuming care of the patient within 24 hours of admission.**

**Recognized Holidays**

Holidays will be treated like weekends with 24-hour call.

**Code pager Coverage**

The Night Float resident will hold the senior code pager at night. Code pagers are to be carried at all times. Please refer to Code blue responsibilities on previous pages for further details.
EMERGENCY MEDICINE SERVICE

This rotation will occur at Wesley Medical Center. During your time in the emergency department (ED) you are under the supervision of the ED attending and should be as respectful and immersed in this experience as professionally required. This is where you get to experience and learn things that are unavailable to you in the rest of your curriculum such as: how to save a child, splint a fracture, suture a laceration, etc. Make the most of this and follow the course syllabus and learning objectives as assigned. Please make sure you listen to the CD lectures and take the tests that are also assigned.

Residents will be required to complete an exam before starting their ED rotation. They should pick up the educational materials needed to study for the exam from the medical education office, which include a DVD and booklets covering important topics in Emergency Medicine. Residents are required to pass the exams for specific topics or they will not be allowed to start working in the ED.
Via Christi Health - St. Francis Night Float/Work Flow

**Intern Night Float (NF)**

NF shifts will begin at 5 pm and end at 7 am the following morning. Interns will be responsible for overnight admissions under the supervision of the senior night float resident. 6am – 7am is time to wrap-up unfinished work. Interns will be responsible for all calls on patients admitted overnight until patients are handed off to the daytime residents. Additionally, interns will be responsible for holding the junior code pager overnight.

NF Interns will be off Saturday night and Sunday night during their NF Block and will be responsible for NF duties beginning Monday night at 5 pm (Mon. 5 pm – Tues. 7 am) and ending with the Friday night shift (Fri. 5 pm – Sat. 7 am).

Interns will usually split monthly duties between night float and a 2-week ambulatory Geriatrics rotation.

3rd year residents will be assigned to night float/supervisory call. Senior residents will be responsible for holding the senior code pager overnight, admitting patients with the intern night float, and performing a face-to-face check-out of overnight admissions.

NF shifts will be from 5 pm–7 am and duties will begin Monday night (Mon. 5 pm-Tues 7am) and end with the Friday night shift (Fri, 5 pm-Sat. 7am). NF 3rd year residents will be off Saturday and Sunday night during their NF Block.

**Face-to-face check-out is mandatory and should be performed between the NF Resident and the Daytime Resident assuming care of overnight admissions. A brief note should be written by the senior On-Call resident or the NF resident and should be on the chart the following morning if the patient had significant changes overnight.**

**Weekend-Call Duties**

Interns not on NF service will be assigned call duties from the On-Call pool of residents and will be responsible for weekend call (admissions and code pager responsibilities) per the following schedule:

1) Saturday morning 7 am – 9pm.
2) Sunday morning 7 am – 9 pm.

2nd year residents (and if needed, non NF 3rd year residents) will be assigned to overnight call per the On-Call schedule. Weekend call (Sat-Sun) will be 7:00am – 7:00am.

**Holidays**

Holidays will be treated like weekends with 24-hour call as scheduled per the On-Call pool of residents if the NF resident is on Holiday leave.

**Admissions & Code pager Coverage**

Senior MED-I/II residents will be responsible for daytime admissions and holding the code pager from 7:00am – 5:00pm. 3rd year NF On-Call will be responsible for holding the code pager as well as overnight admissions from 5:00pm – 7:00am. Junior MED I/II residents will be responsible for holding the junior code pager and for daytime admissions (under the supervision of the senior resident) from 7:00am – 5:00pm and should be allowed to complete pre-rounding responsibilities on their patients prior to morning report. NF interns will be responsible for holding the junior code pager and for overnight admissions (under the supervision of the On-Call senior resident) from 5:00pm – 7:00am.
Resident Continuity Clinic

The goal of resident clinic is to provide a personal patient panel with whom to develop a relationship providing long term care.

In the 4 + 1 system, residents are grouped in teams and attend clinic in a “block” of five consecutive days every fifth week. One clinic is considered a one-half day experience. During this time period you will see patients from your panel of patients as well as hospital follow-up and call-in patient visits. You are assigned a nurse with whom you will work for the duration of your resident experience.

Clinic begins at 8 AM or 1 PM. The number of clinic openings depends on your level of training. Schedules may change even on the day of clinic so keep an eye on your list. Even if you have openings in your schedule, you are expected to arrive in clinic on time and stay on the physical premise until the completion of clinic.

Charts are computerized and once eClinicalWorks is implemented (estimated September 2014) you will have access through the internet. After an individual patient visit, you will check out with one of the clinic attendings who will discuss the treatment plan you have designed. The attending may or may not physically see your patient. Your computer chart note should be completed and submitted to the clinic attending with whom you discussed the plan of care.

Paperwork is a necessary part of a physicians’ daily workflow. Each resident has a clinic folder. The paperwork has been sorted and only those documents requiring review or signature are placed in this folder. Please respond promptly as patient care may be affected by delays.

Each resident is responsible for their clinic patients regardless if they are physically in clinic. Your nurse will text or call you with urgent issues. Your patient’s may page you after hours or on weekends. Please remember to check out through the hospital operator if you are going to be unavailable. Communicate directly to your nurse if you are gone.

Post-call/Night Float
When a resident is post call or on night float, s/he is still responsible for clinic patients. Please notify your nurse so she can contact you about patient concerns later in the day.

Controlled Substances Policy
KU Internal Medicine has implemented a well-defined narcotic use policy. This policy prohibits narcotic prescriptions after hours or on weekends.

<table>
<thead>
<tr>
<th>PGY 1</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Clinic</td>
<td>Clinic</td>
<td>Clinic</td>
<td>Clinic</td>
<td>Clinic</td>
</tr>
<tr>
<td>PM</td>
<td>Board review</td>
<td>Procedures</td>
<td>Team</td>
<td>Sim Code</td>
<td>Admin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PGY 2</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Clinic</td>
<td>IPA</td>
<td>Clinic</td>
<td>Oral exam Procedures</td>
<td>Clinic</td>
</tr>
<tr>
<td>PM</td>
<td>Board review</td>
<td>Clinic</td>
<td>Team</td>
<td>Clinic</td>
<td>Admin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PGY 3</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Clinic Procedures</td>
<td>Clinic</td>
<td>Clinic Procedures</td>
<td>Clinic</td>
<td>Clinic</td>
</tr>
<tr>
<td>PM</td>
<td>Board review</td>
<td>Clinic</td>
<td>Team</td>
<td>Oral exam Sim Code</td>
<td>Admin</td>
</tr>
</tbody>
</table>
Resident Leave Policy

(All leave must follow the leave request process on page 32)

Personal Days Off (Med/CC/NF rotations)
The Accreditation Council for Graduate Medical Education (ACGME) requires all residents to have at least one day out of seven, averaged over a four-week period, free of educational and clinical duties (a total of four days per month). The date of the days off must be approved by the faculty member on service and, if applicable, coordinated with the senior resident and the other intern. No more than one resident of a team should be absent at any one time. The four days should not run concurrently (i.e., Thursday through Sunday), unless approved by the department. Personal days may not be accumulated from month to month.

Personal days off do not have to be constricted to weekends. However, if residents choose weekends for personal days off, First-year residents typically can have one weekend off per month and second- and third-year residents typically have two (2) weekends off per month. Med teams should discuss their schedules at the beginning of the month to determine intern & senior personal days off.

Vacation Leave (Subspeciality & Elective rotations)
Vacation leave is 15 weekdays. To receive a passable rotation evaluation, the department suggests that no more than five (5) days should be requested during any rotation, except in special circumstances. Extended vacation leave (i.e., more than 5 days) will be reviewed by the program director and should not be considered approved until the resident receives an email confirmation of approval. Requests for extended vacation (greater than 2 weeks) must be submitted to the residency office by September 1st. Extended vacation time must not be connected with program approved holiday leave. Holiday leave may be withdrawn by the program director in lieu of vacation time approved during the November or December holidays. Vacation leave is not approved while on the following rotations: general medicine ward, VACC, VC pulm-cc, neuro-cc, ambulatory clinic week. Exceptions may be made for extraordinary circumstances.

Educational Leave
The resident may apply for paid leave time to attend educational meetings. This time is granted at the discretion of the Program Director. The resident may utilize the educational resources stipend ($1000/year with carry-over from year-to-year) to attend educational meetings. Meetings considered for educational leave include those in which the resident is presenting a paper or poster, those that provide special training or knowledge that would be applied in a subsequent research project, or those that provide relevant education not available through routine outlets. The leave request form must be submitted with the educational meeting agenda and payment confirmation form attached.

Sick Leave
Ten days paid sick leave per year is provided. The residency office, the Patient Care Clinic, supervising faculty, and senior residents (as appropriate) should be notified promptly of any illness that prevents the resident from meeting his/her patient and educational responsibilities. The following procedures must be followed when requested sick leave.
♦ Senior residents must call their attending physician, then call the departmental residency office.
♦ Junior residents who are not on a med 1 service must call their attending physician, then call the departmental residency office.
♦ Junior residents at the VA must call their Senior colleague at the VA, who will notify the attending. The resident requesting sick leave also must call the departmental residency office.
♦ Junior residents on a med 1 service must call their Senior resident, who will notify the attending. The resident requesting sick leave also must call the departmental residency office.
♦ If the illness occurs during a clinic day, the clinic must be notified promptly. Residents are requested to call the Patient Care Coordinator and/or office manager.
♦ If the illness occurs when a resident is on call, a Chief Resident and the attending physician must be notified.

When calling the departmental residency office outside of business hours (Monday through Friday, 7 am – 5 pm), leave a clear message with name, date, the time leaving service, expected time to return to work and identify who you will be checked out to for patient calls. The resident should follow-up with residency staff during office hours to confirm leave information.

**Fellowship and Employment Interviews (PGY 3 only)**
Ten days paid leave for fellowship interviews are provided. A leave form must be filled out and outpatient and call arrangements should be made by the resident in order for approval. If leave for fellowship interviews extends beyond 10 days, residents will be required to take vacation leave.

**Maternity/Paternity Leave**
Vacation and/or sick leave must be used for maternity/paternity leave. When vacation and sick leave have been exhausted residents are required to take leave without pay. All maternity/paternity leave requests must be submitted 60 days in advance of the FIRST day of the block affected. Due to the uncertainty of the due date, leave requests will remain flexible. Backup coverage will assessed on a case by case basis. FMLA paperwork needs to be filed with WCGME.

**Holiday And Year-End Leave**
Leave is prohibited during:
♦ the first two (2) weeks of July,
♦ during the week of In Training Exams (approx. 2nd or 3rd week of October)
♦ the days surrounding the Thanksgiving holiday weekend
♦ the last two (2) weeks of December**
♦ the last two (2) weeks of June**

**In cases of unique or special needs, the resident may request vacation during this time (no more than 5 days), but it will be granted only after approval of the program director. Preliminary residents and PGY-3 graduating seniors who must leave before June 30 to travel to their practice or continuing education program must utilize vacation time to do so. Forms must be submitted to the residency office 45 days in advance of their departure. It is imperative that patient care needs not be jeopardized during any vacation or leave.**

**ACP Conference**
All residents are encouraged to attend the Kansas Regional American College of Physicians meeting. Time in attendance at this meeting will not be deducted from vacation or meeting time allotments.

**Accumulation Of Leave**
Vacation and educational leave may not be accumulated from year to year. Sick leave may be accumulated up to a maximum of 30 days.

**Process for Leave Requests**
This policy has been put in place in order to ensure patient safety and also as protection for the resident if issues arise on their leave. This will allow for fewer errors and a more consistent process for call, clinic, and schedules.

1. Residents are required to obtain a leave request form from the IM office (for vacation, illness, educational leave, fellowship, LWOP and personal time off if affects clinic, call or out of range for pager).
2. Leave requests must be submitted 60 days in advance of the FIRST day of the block affected if you want to be blocked from call and clinic (deadline dates are posted on the IM website -
Vacation requests must be placed 60 days in advance so that hospital call, patient care, and other responsibilities can be maintained.

3. The leave request form must be completely filled before submitting to the residency office.
   - Identify resident(s) who will cover your patient care; obtain signatures of the resident covering your patient care;
   - Identify a resident who will cover your back up responsibilities (if applicable), obtain the signature of that resident (cannot be a resident on a Med/NF/CC rotation);
   - Obtain your rotation attending’s signature. Signatures can be obtained through fax or written approval via email (must attach fax or email to the leave request form). If you are unable to obtain the attending’s signature due to their not responding, please provide documentation of your attempt to contact them.
   - All signatures obtained via fax or email must be attached to the leave form when you submit it. DO NOT EMAIL THE ATTENDING’S OR RESIDENT COVERAGE EMAIL TO THE RESIDENCY OFFICE, IT MUST BE ATTACHED TO YOUR LEAVE FORM WHEN YOU SUBMIT.
   - The dates of the leave should include weekend dates. Weekend dates will not be deducted from resident leave benefits.

4. If the leave request is submitted after the deadline, you will not be blocked from call. If you are assigned call during your leave dates, you will be responsible for finding someone to cover your call; you must notify the IM office of that switch.

5. The resident is responsible to meet all scheduled patient care activities (e.g., clinic and call). The resident is responsible for obtaining coverage for scheduled activities. If coverage is not obtained, the resident is responsible to fulfill his/her patient care obligations, **even if the leave is approved**. If such is not the case and the Program Director, supervising faculty, or Director of Internal Medicine Education determines that patient care may be jeopardized, the approval for leave may be denied and the leave may need postponed.

6. Residents will be notified via email on whether their leave request has been approved. Your request is NOT approved until you receive notification.

No leave form will be accepted until all requirements are met.
Moonlighting & Locum Tenens

Moonlighting & Locum Tenens Policy
Residents may not be required to engage in moonlighting or locum tenens activities; however, if a resident desires to engage in moonlighting or locum tenens activities the following guidelines must be followed. Moonlighting and locum tenens must never interfere with regular resident responsibilities. Moonlighting residents are expected to be present (and appropriately rested) in their educational setting during all prescribed hours. Moonlighting and locum tenens must never occur without advance written permission of a resident’s Program Director. The resident’s performance will be monitored by the Program Director for the effect of these activities upon residency performance.

Moonlighting:
Moonlighting is defined as any remunerative activity, outside the requirements of the residency program, in which an individual performs duties related to health care. This includes, but is not limited to: providing direct patient care, conducting “wellness” physical examinations, reviewing medical charts, EKGs, or other information for a company or an agency, clinical teaching in a medical school, providing medical opinions or testimony in court or to other agencies, and serving as a sports team physician or medical official for an event.

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Internal and External remunerative Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

Any moonlighting by a resident at any of the following organizations is considered “internal” moonlighting, and hours spent moonlighting at these organizations must be counted against the resident’s 80-hour workweek total: Wesley Medical Center, Via Christi Hospitals Wichita, Inc., and Salina Regional Health Center. Reporting of the hours is the resident’s responsibility. Residents may be granted permission to moonlight only if they have obtained full licensure from the Kansas State Board of Healing Arts and have their own individual DEA registration number. Residents working under J-1 sponsorship are prohibited from engaging in outside remunerative activities of any kind. This is a condition of the J-1 visa under ECFMG and INS regulations. PGY-1 residents are not permitted to moonlight.

Program Directors, acting as agents of the Dean and the University, will establish policies governing moonlighting activities for their residents that are in compliance with university and Residency Review Committee guidelines. These policies establish the maximum number of hours that a resident will be permitted to moonlight per week, month and year. Policies and procedures for requesting and granting permission for moonlighting are the responsibility of each Residency Program and its Program Director and/or Departmental Chair. Residents on formal probation may not participate in moonlighting activities until they have been restored to good standing in their programs. A copy of the letter approval form for moonlighting and locum tenens must be kept in the resident’s program file.

KUSM-W residents are provided professional liability insurance via a State of Kansas self-insurance program. This insurance (occurrence type with tail and with the following limits: basic coverage $200,000/600,000; excess coverage $800,000/2,400,000) covers residency-related acts performed under the supervision of a member of the residency teaching staff and approved locum tenens, but DOES NOT cover moonlighting activities. Additional occurrence type insurance, with limits of coverage not less than those provided via the state plan, must be arranged to cover moonlighting activities. Such insurance may be purchased by the resident or may be arranged by another individual/agency (i.e., the moonlighting employer). If the resident is not personally responsible for purchasing the additional coverage, he/she must request a certificate of insurance to document the existence of the appropriate coverage.

Salary advances (zero percent interest loans) to cover the cost of premiums for such insurance are available via the WCGME office.

Residents moonlighting at a VA Medical Center do not need to purchase additional insurance to cover their VA moonlighting activities if they have signed “fee basis agreements” which result in their appointment to the VA Medical Staff. As such, the residents are covered by the Federal Tort Claims Act and do not require individual Professional Liability Insurance coverage.
Approved Moonlighting Sites
The following sites have been approved by the Department of Internal Medicine. Any resident moonlighting at an unapproved site is in violation of the guidelines and will be subject to revocation of moonlighting privileges.

- Via Christi Regional Medical Center-St. Francis /E.R. and MECS
- Wesley Medical Center/E.R. and MECS
- Via Christi Regional Medical Center-St. Joseph /E.R. and MECS
- Wichita Clinic Ambulatory Care Clinic and Maple Ridge
- McConnell Air Force Base
- Emergency Services of Kansas - Newton site only
- Hospice Services of Wichita - Attending: Gerard Brungardt, MD

Locum Tenens:
Locum tenens activities approved, in advance, by a resident’s Program Director, Chief Operating Officer and Executive Vice Chancellor, will be covered by the resident’s state-provided insurance and do not require the purchase of additional coverage. Locum tenens activities are considered to be controlled situations in which a KUSM-W Residency Program responds to a request from a Kansas physician for a qualified resident to provide “coverage” for him or her while away from the usual site of practice for a limited time due to illness, vacation or attendance at a continuing medical education activity.

Locum tenens activities will typically occur only in “rural” communities. A request for a locum tenens activity in a more urban setting will not be approved unless there are unusual extenuating circumstances. Resident coverage for a practicing physician should not be requested unless coverage via other physicians in the community is impossible or inappropriate. Forms to be used in requesting approval for coverage of locum tenens activities to ensure state-provided insurance must be submitted at least two weeks in advance of the activity to the WCGME office. These forms are available at the program and WCGME offices. To insure that liability coverage is available, residents should also complete a locum tenens form for any clinical volunteer work outside of the JayDoc clinic.

The resident’s performance will be monitored for the effect of these activities upon performance. Any adverse effects may lead to withdraw of permission for moonlighting and/or locum tenens.
Recognizing Resident Fatigue

The Internal Medicine Residency Program recommends that you view this video for sleep deprivation and fatigue education, as emphasized by the accreditation council for residency programs, ACGME. It was developed by a committee of the American Academy of Sleep Medicine. Link: [http://wichita.kumc.edu/wcgme/sleep-fatigue-training.html](http://wichita.kumc.edu/wcgme/sleep-fatigue-training.html), (SAFER) - Sleep Alertness and Fatigue Education in Residency.

Fatigued residents typically have difficulty with:
- Appreciating a complex situation while avoiding distraction
- Keeping track of the current situation and updating strategies
- Thinking laterally and being innovative
- Assessing risk and/or anticipating consequences
- Maintaining interest in outcomes
- Controlling mood and avoiding inappropriate behavior

Neurobehavioral effects of sleep loss are:
- Voluntary and involuntary sleep latencies shorten
- Microsleeps intrude into wakefulness
- Behavioral lapsing (errors of omission)
- False responses (errors of commission)
- Time-on-task decrements (fatigue)
- Cognitive speed/accuracy trade-off
- Learning and recall deficits
- Working memory and related executive functions decline

The effects of sleep deprivation are:
- Increased moment-to-moment variability in attention and waking cognitive functions requiring executive attention processes
- Tasks requiring sustained attention and rapid responses are vulnerable
- A differential vulnerability where some people are impaired sooner and more severely than others

Chronic partial sleep deprivation may lead to neurobehavioral deficits as severe as those with total sleep deprivation, but the affected person may not appreciate the impairment risk fully.

High risk times for fatigue-related symptoms are:
- Midnight to 6 am
- Early hours of day shifts
- First night shift or call night after a break
- Change of service
- First 2 to 3 hours of a shift or end of a shift
- Early in residency or when new to night call

Understanding Sleep Inertia

Sleep inertia is disorientation, confusion, and cognitive dysfunction that occurs upon awakening from deep sleep, and/or sleep in the middle of the night, and/or sleep following sleep deprivation.

Sleep inertia:
- Can be a problem for physicians on call
- Affects a wide range of cognitive performance functions adversely
- Occurs with as little as 30 minutes of sleep
- Can require up to a 2-hour recovery rate
- May manifest an amnesia for the “awakening” and cognition that occurred during it
- May be reduced by increased metabolic activity (e.g., exercise, caffeine)
**Caffeine Use for Fatigue Management**
Caffeine promotes alertness if used strategically/prophylactically rather than socially. Caffeine is not a substitute for sleep. It may benefit alertness for only 3-10 hours. Some people do not tolerate caffeine well and it can lead to tolerance and adverse physiological effects.

**Naps for Fatigue Management**
Naps promote alertness and cognitive performance, especially if taken prophylactically before sleep loss becomes too severe. Naps also have neurocognitive benefits when sleep is chronically restricted. HOWEVER…Naps may not produce a subjective sense of recovery. Naps often produce sleep inertia and its negative consequences (see above).

**Managing Fatigue**
- Limit prolonged work periods (24-hour periods)
- Protect recovery sleep periods (24 hours off duty)
- Avoid rapid or frequent shifts from day to night work
- Provide education on fatigue effects and management
- Use power napping strategically and prophylactically
- Use caffeine and food strategically and prophylactically
- Reduce non-essential performance tasks
- Inculcate a culture of shared responsibility
- Rule out physical illness masking as fatigue
- Rule out mental health issues that may manifest as fatigue
- Individualize schedules to accommodate idiosyncratic energy cycles
- Provide optimal working and sleeping environments
- Anticipate and monitor fatigue in residents

**Resident Fatigue Policy**
When attending faculty observe a resident who displays signs of excessive fatigue or sleep deprivation, the program director should be notified. With the program director’s approval, the resident’s work period will be limited by one or more of the following steps:
- Send the resident home to sleep for a adequate period of time (up to 24 hours)
- Have another resident or attending cover for the resident’s work responsibilities
- Institute the back-up plan to cover med 1 or call responsibilities
- Recommend that the resident seek appropriate medical care

**Resource Materials**
Bienenfeld DG  Recognizing resident fatigue.  A guide for training directors and faculty.  
[http://www.dagmec.org/fatigue.htm](http://www.dagmec.org/fatigue.htm).


**Substance Abuse Policy:**
Please refer to the WCGME policy regarding substance abuse on their website at  
[http://wichita.kumc.edu/wcgme/policies/Substance_Abuse_Policy.pdf](http://wichita.kumc.edu/wcgme/policies/Substance_Abuse_Policy.pdf)
Protocol For Professional Liability Actions

You may be requested to testify in court, deliver a deposition, or meet with attorneys to discuss a case you were involved with as part of your professional service or education or be named as defendant in a litigation case. Before proceeding with any action, contact the Program Director, then immediately provide the original copy of the notification to the WCGME office. The WCGME office will be responsible in notifying the Risk Management office at the KU Medical Center who will notify the Kansas Health Care Stabilization Fund. No exceptions to this protocol should occur.

Protocol When Involved In Malpractice Activity

If a resident is named as a defendant in a malpractice action, the Program Director should be notified immediately. The resident must provide the WCGME office with the original copy of the notification. WCGME is responsible for notifying the appropriate individuals at the KU Medical Center and the Kansas Health Care Stabilization Fund. A representative of either KUMC or the "Fund" will contact the resident with advice concerning any action that should or should not be taken in regard to the pending malpractice suit. The resident should not contact an attorney until he or she is notified by the insurance carrier(s) (KUMC and the “Fund”) regarding the attorney appointed to represent him or her.

If a resident is involved in a patient care incident that he or she suspects might lead to litigation, the WCGME office should be notified in writing so that the insurance carrier(s) can be alerted to any potential activity. Questions or concerns about professional liability insurance coverage or actions to be taken in the event a resident is named a defendant in a suit should be directed to the Program Director or the WCGME office.

Reporting Obligations Under House Bill 2661

Kansas law requires all health care personnel to be vigilant for and report to the proper authorities any occurrences or situations which are below the standard of good care or grounds for disciplinary action by the Kansas State Board of Healing Arts. Failure to comply with this law is punishable by imprisonment and/or a monetary fine as well as revocation of one's license to practice medicine. The reporting person is immune from prosecution unless bad faith is shown. The report is confidential and is not admissible in any civil lawsuit or administrative proceeding.

The reporting process for incidents which occur in our teaching hospitals should be directed in writing to the Director of Internal Medicine Education using the Incident Report Form. They will notify the proper investigative committee at the hospital. Incidents that occur in the KUSM-W clinic should be reported to Lorene Valentine, Practice Plan Manager. Incidents occurring outside our teaching facilities should be reported to the Board of Healing Arts or the Sedgwick County Medical Society.

Any problems that residents observe with the performance of their peers should be brought to the attention of the Director of Internal Medicine Education or Program Director who is responsible for further investigation and counseling. The Problem Incident Report form should be used.

House Bill 2661 which was signed into law April 19, 1986 makes substantial changes in hospital risk management procedures and reporting obligations by all persons involved in the delivery of health care. Beginning July 1, 1986, all persons involved in the delivery of health care in Kansas will have an affirmative duty to report incidents that may be below the standard of care, or may be grounds for disciplinary action by the Board of Healing Arts. Hospitals have additional reporting obligations.
The reporting process differs depending upon where the incident occurs. However, the persons designated as mandated reporters and the acts which must be reported are the same. A special procedure applies to impaired providers.

**Hospital Reporting Requirements**

Under HB 2661, three reports must be made by hospitals.

1. After investigation, any report that finds a departure from the standard of care, or a disciplinary infraction must be forwarded to the appropriate licensing agency.
2. Reports to the appropriate licensing agency of the suspension, termination, restriction, limitation, or voluntary surrender of practice privileges due to professional incompetency.
3. Quarterly reports to the appropriate licensing agency. These reports are issued every three months after July 1, 1986, and include the number of incident reports received, whether an investigation was conducted, and action taken as a result of the investigation.

Professional Societies must also submit reports 1 and 3 as noted above.

**Situations Required To Be Reported**

1. Knowledge that another health care provider, medical care facility employee, or a person acting on behalf of a medical care facility has acted in a manner that is or may be below the applicable standard of care must be reported. The phrase "standard of care" is a legal term. Simply, it means that a health care provider must have the same degree of skill and knowledge as his peers, and must use this skill and knowledge in a careful and diligent manner. Obviously, certain acts are substandard, while others require the reporting provider to use his personal judgment regarding the care and skill exercised.

2. Knowledge that a person licensed to practice by the Board of Healing Arts (a person licensed to practice medicine and surgery, osteopathic medicine and surgery, and chiropractors) has committed any of the following acts:
   - A) Fraud or misrepresentation when applying for a license
   - B) Unprofessional of dishonorable conduct
   - C) Conviction of a felony or class A misdemeanor
   - D) Fraudulent or false advertising
   - E) Addiction to or distribution of intoxicating liquors or drugs
   - F) Practice of a branch of healing arts in which the person is not licensed
   - G) Failure to pay annual renewal fees
   - H) Failure to take continuing education
   - I) Engaging in the practice of the healing arts under a false or assumed name
   - J) Inability to practice the branch of healing arts with reasonable skill or safety by reason of an illness; alcoholism; excessive use of drugs, controlled substances, chemicals or other types of materials; or as a result of any mental or physical condition.
   - K) Disciplinary action taken against the licensee
   - L) Failure to report any knowledge required to be reported
   - M) Failure to inform a patient suffering from any abnormality of breast tissue of alternative methods of treatment
   - N) Cheating on a licensure examination
   - O) Mental illness or disability or the licensee has been found not guilty by reason of insanity or incompetent to stand trial
   - P) Selling, administering, distributing a controlled substance for other than medically accepted therapeutic purposes
   - Q) Violation of a federal law relating to controlled substances
   - R) Failure to furnish the Board of Healing Arts, its investigators or representatives, information requested by the Board
S) Peer review committee action taken against the licensee, or failure to report to the Board any adverse action taken against him by another state
T) Surrendering a license or authorization to practice in another state, or failure to report to the Board surrender of a license or authorization to practice in another state
U) An adverse judgment, award or settlement resulting from medical liability, or failure to report any adverse settlement, judgment or award relating to any act which would be cause for disciplinary action
V) Failure to maintain professional liability insurance, or failure to pay the annual surcharge
W) Failure to adhere to the standard of care to a degree constituting gross negligence
X) Repeated failure to adhere to the standard of care, a pattern of practice or behavior which manifests incapacity or incompetence to practice medicine
Y) Representing to a patient that has a manifestly incurable disease, condition or injury that it could be cured
Z) Care and treatment of a patient without consent
AA) Indicating that he has a license to practice a branch of healing arts which he is not licensed to practice
BB) Performing, procuring or aiding a criminal abortion
CC) Willful betrayal of confidential information
DD) Advertising a guarantee of a professional service
EE) Participation in an action as a staff member designed to exclude another practitioner of the healing arts without just cause
FF) Prescribing, ordering, dispensing, administering or selling amphetamines or sympathomimetic amines, except as authorized by statutes
GG) Engaging in conduct likely to deceive, defraud or harm the public
HH) False or misleading statements regarding his skills or the value of a drug or treatment
II) Aiding the practice of medicine by an unlicensed, incompetent or impaired person
JJ) Allowing another person or organization to use his license
KK) Sexual abuse, misconduct or exploitation related to a license to practice medicine
LL) Obtaining a fee by fraud, deceit or misrepresentation
MM) Directly or indirectly giving or receiving a fee, commission, rebate or other compensation for services not actually or professionally rendered
NN) Failure to transfer medicine records to another physician when requested to do so
OO) Performing unnecessary tests, examinations or services without legitimate medical purpose
PP) Charging excessive fees for services rendered
QQ) Prescribing, dispensing, administering, distributing a prescription drug or substance including a controlled substance in an excessive or improper manner
RR) Failure to practice healing arts with the level of care, skill and treatment recognized by reasonably prudent practitioners as being acceptable under similar conditions and circumstances
SS) Failure to keep written medical records
TT) Delegating professional responsibilities to an unqualified person
UU) Using experimental forms of therapy without proper informed consent

**Persons Required To Report**

1. All health care providers
2. A person licensed to practice any branch of the healing arts
3. A person who holds a temporary permit to practice any branch of the healing arts
4. A person engaged in a post-graduate training program approved by the Board of Healing Arts
5. All persons employed by a medical care facility
6. All persons employed by a health maintenance organization
7. All persons employed by a mental health center or clinic
8. All members and employees of professional corporations, partnerships, or no-profit corporation which are organized to render health care services
9. Optometrists
10. Podiatrists
11. Pharmacists
12. Licensed professional nurses who are certified as anesthetists
13. Dentists who are certified to administer anesthetics
14. Physical therapists
15. Chiropractors
16. All persons acting on behalf of a medical care facility

**Reporting Procedure (3 Schemes)**

**Acts by a health care provider outside a hospital**

Incident outside a medical care facility

- Report to State or County Professional Society
  - OR
  - State Licensing Agency

Review by Professional Practices Review Committee

- Conclusions that provider did not act beneath the standard of care
- Findings that provider acted beneath the standard of care are reported to State Licensing Agencies

**Acts by a health care provider inside a hospital**

Incident inside a medical care facility

- Report to Chief of Medical Staff, Chief Executive Office, Risk Manager
  - OR
  - State Licensing Agency

Reviewed by Hospital Investigative Committee

- Conclusions that provider did not act beneath the standard of care
- Findings that provider acted beneath the standard of care are reported to State Licensing Agencies
Acts by a hospital, its agents or employees

Acts by a hospital, its agents or employees

Incident by a medical care facility

Report to Chief of Medical Staff, Chief Executive Office, Risk Manager

OR

Department of Health and Environment

Reviewed by Hospital Investigative Committee

Conclusions that provider did not act beneath the standard of care

Findings that provider acted beneath the standard of care are reported to State Licensing Agencies

Impaired Providers

When a report concerns a provider who is impaired because of physical or mental disability including that caused by drug or alcohol abuse, the report may be made directly to the proper licensing agency or through normal channels. If after investigation, the investigative committee finds impairment, it can report its findings to the licensing agency or to an impaired provider committee. A report to an impaired provider committee is considered the same as a report to the licensing agency. Whenever the licensing agency has reasonable cause (through a report or independently) to believe that a provider is impaired, it may cause an evaluation to be made by the impaired provider committee.

Licensing agencies may contract with impaired provider committees to deal with an impaired provider. The committees evaluate reports of suspected impairment, contract with treatment programs, and monitor treatment and post-treatment progress.

The various licensing agencies and impaired provider committees will enter into agreement regarding periodic reporting of statistical data, periodic joint review of information regarding reports and investigations, disposition of reports and contracts for treatment. Whenever the licensee is an imminent danger to himself or others, the impaired provider committee must immediately report this information to the licensing agency. The committee also must tell the licensing agency when an impaired provider refuses to submit to treatment, whose impairment is not helped by treatment, who is professionally incompetent, or who refuses to cooperate with the committee. An impaired provider may request his license be limited during treatment.

Hospitals may not exclude a provider if he has successfully completed a treatment program, solely on the grounds that he has been impaired. However, impairment may be considered by hospitals in determining the scope of privileges granted. Impaired provider committees are not liable for acts done or recommendations made in good faith and their reports are confidential.

Immunities, Confidentiality, And Other Protections

Reports and records made under HB 2661 are confidential and are not admissible in any civil lawsuit or administrative proceeding, except a disciplinary action by the licensing agency. Persons who attend meetings of any review committee or receive reports or records cannot be compelled to testify in a civil, criminal, or administrative proceeding unless it is a disciplinary action by the licensing agency. These persons will not be liable in damages unless bad faith is shown. If a person or entity fails to report, or a medical care facility or
professional society fails to investigate a report, they will not be liable for damages in a civil lawsuit. However, other penalties are imposed by HB 2661 for failure to report (see page 31).

An employee is safe from being discharged or discriminated against simply because he made a report. Employers may be liable for lost wages, damages, and attorney fees if the above occurs.

**Antitrust Implications**

Hospital medical staff can take the following actions to reduce the potential for liability in the event of an antitrust claim:

1. Peer review should always adhere rigorously to the provisions of any applicable bylaws. Any deviation in the case of a particular practitioner leaves room for an inference of special treatment motivated by anti-competitive considerations not appropriate to the peer review process.
2. The procedure also should provide ample due process. Practitioners should have full notice of the “charges” against them and ample opportunity to rebut them. An appeals process also should be provided so that the final decision results from careful and detailed consideration.
3. The process should minimize the likelihood that direct competitors or particular practitioners would have veto power over an application for privileges. Credentials committees must conduct their own independent evaluation and investigation and the composition of the committee should not be slanted unduly in favor of a particular group or specialty.
4. A medical staff should not hesitate to retain an independent consultant to review a particular matter. The reporting provisions of HB 2661 do not apply to a health care provider who is acting as a consultant or providing additional review.
5. Any action and the reasons for it should be fully documented.

**Penalties For Failure To Report**

- A willful and knowing failure to make a required report is a class C misdemeanor, punishable by a jail term of under one month and a sum not exceeding $500.00.
- Any person or entity holding a license to render health care services who willfully and knowingly fails to make a required report is subject to disciplinary action by his licensing agency. The license may be revoked, suspended or limited, or the licensee subject to public or private censure.
- Failure of a medical care facility to report to the Board of Healing Arts within 30 days whenever it receives information that a licensee of the Board has committed an act is grounds for a daily fine of $1,000.00.
Universal Blood & Body Substance Precautions

All health care facilities involved in our educational activities have instituted identical policies to minimize the risk of exposure to blood borne infectious agents. These recommendations require the use of barrier protective devices to prevent inoculation of all patient body fluids and blood into the tissues or on mucus membranes of health care workers. This precaution should be used on all patients regardless of their serologic status or risk of infection.

**Practices/Precautions**

A. Personal Protective Equipment
   1. Use gloves where blood, blood products, or body fluids or equipment contaminated with blood or body fluids will be handled.
   2. Use gowns, masks, and eye protectors for procedures that could involve more extensive splashing of blood or body fluids.
   3. Use pocket masks, resuscitation bags, or other ventilation devices to resuscitate a patient to minimize exposure that may occur during emergency mouth-to-mouth resuscitation. These devices will be placed where the need for resuscitation is likely.

B. Workplace Practices
   1. Wash hands thoroughly after removing gloves and immediately after contact with blood or body fluids.
   2. Use disposable needles and syringes whenever possible. Do not recap, bend, or cut needles. Immediately after use, place needles and sharps in puncture resistant containers located in either patient's room or medication rooms and/or carts.
   3. Follow established guidelines for sterilization, disinfection, housekeeping, and waste disposal. Place potentially infective wastes in impervious bags and dispose of them in accordance with the hospital or clinic policy.
   4. Clean up blood spills immediately with detergent and water. Use a solution of 5.24% sodium hypochlorite (household bleach) diluted between 1-10 and 1-100 parts water for disinfection.

C. Other Recommendations for Prevention
   1. Treat ALL blood and body fluids as potentially infectious.
   2. Workers at substantial risk of acquiring HBV infection should receive an HBV vaccination.

D. Hepatitis B vaccination is strongly encouraged and is available at no charge to the resident.
APPENDIX A

Administrative Staff in the Department of Internal Medicine

KUSM-W
Jon P. Schrage, M.D., M.P.A
William Salyers, M.D., M.P.H.
Tom Schulz, M.D.
Jennifer Jackson
K. James Kallail, Ph.D.
Jill Longstaff

293-2604 (FAX 293-1878)
Professor and Chairman
Program Director/Assistant Professor
Associate Program Director/Assistant Professor
Associate Program Director
Associate Chair for Research
Department Administrator

Andrea Vogelman
Laurie Fluty
Jean Olsen
Marilane Carr
Monica Ledbetter

Senior Residency Coordinator
Residency Coordinator
Student Education Coordinator
Senior Project Coordinator
Office Coordinator

KU CENTER FOR INTERNAL MEDICINE CLINIC (Resident Clinic)
Jennifer Jackson, M.D.
Deb McSwain, L.P.N

293-1818
Director
Clinic Manager

WESLEY MEDICAL CENTER
Melissa Gaines, M.D.
Janell Vulgamore

962-2212
Director, IM Education
Residency Coordinator, IM Education
Medicine / Pediatrics Residency Coordinator

VA MEDICAL CENTER
Mona Brake, M.D.
Trudy Hill

688-6799 (Ext 3440)
Director, IM Education
Admin. Assistant and Affiliations Coordinator

VIA-CHRISTI HEALTH ST. FRANCIS CAMPUS
Donna Sweet, M.D.
Sherri Skupa

268-5894
Director, IM Education
Secretary, IM Education
APPENDIX B
ACGME General Competencies/ACGME Milestones/Curricular Milestones

The residency program must require its residents to develop the competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed for their residents to demonstrate the competencies.

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

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- Gather essential and accurate information about their patients
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- Develop and carry out patient management plans
- Counsel and educate patients and their families
- Use information technology to support patient care decisions and patient education
- Perform competently all medical and invasive procedures considered essential for the area of practice
- Provide health care services aimed at preventing health problems or maintaining health
- Work with health care professionals, including those from other disciplines, to provide patient-focused care

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

- Demonstrate an investigatory and analytic thinking approach to clinical situations
- Know and apply the basic and clinically supportive sciences which are appropriate to their discipline

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

- Analyze practice experience and perform practice-based improvement activities using a systematic methodology
- Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- Use information technology to manage information, access on-line medical information, and support their own education
- Facilitate the learning of students and other health care professionals
INTERPERSONAL AND COMMUNICATION SKILLS
Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates. Residents are expected to:

- Create and sustain a therapeutic and ethically sound relationship with patients
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Work effectively with others as a member or leader of a health care team or other professional group

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

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

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

- Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for quality patient care and assist patients in dealing with system complexities
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

ACGME Milestones
The ACGME milestones can be found at the end of this document.

Curricular Milestones Legend & Trainee Timeline Map
Legend to be used for mapping of Curricular Milestones to rotation Goals and Learning Objectives. The timeline map of development is highlighted within each sub-competency area within the 6 Core Competencies (Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communications Skills, Professionalism, and Systems-Based Practice) and provide a suggested timeline for resident physician development in Internal Medicine.

1) Patient Care
   Historical Data Gathering:
   - Acquire accurate and relevant history from the patient in an efficiently customized, prioritized, and hypothesis driven fashion (PC-A1) (6 months)
• Seek and obtain appropriate, verified, and prioritized data from secondary sources (e.g. family, records, pharmacy) (PC-A2) (9 months)

• Obtain relevant historical subtleties that inform and prioritize both differential diagnoses and diagnostic plans, including sensitive, complicated, and detailed information that may not often be volunteered by the patient (PC-A3) (18 months)

• Role model gathering subtle and reliable information from the patient for junior members of the health care team (PC-A4) (30 months)

Performing a Physical Exam:

• Perform an accurate physical examination that is appropriately targeted to the patient’s complaints and medical conditions. Identify pertinent abnormalities using common maneuvers (PC-B1) (6 months)

• Accurately track important changes in the physical examination over time in the outpatient and inpatient settings (PC-B2) (12 months)

• Demonstrate and teach how to elicit important physical findings for junior members of the health care team (PC-B3) (24 months)

• Routinely identify subtle or unusual physical findings that may influence clinical decision making, using advanced maneuvers where applicable (PC-B4) (30 months)

Clinical Reasoning:

• Synthesize all available data, including interview, physical examination, and preliminary laboratory data, to define each patient’s central clinical problem (PC-C1) (12 months)

• Develop prioritized differential diagnoses, evidence-based diagnostic and therapeutic plan for common inpatient and ambulatory conditions (PC-C2) (12 months)

• Modify differential diagnosis and care plan based on clinical course and data as appropriate (PC-C3) (24 months)

• Recognize disease presentations that deviate from common patterns and that require complex decision making (PC-C4) (36 months)

Invasive Procedures:

• Appropriate performance of invasive procedures and provide post-procedure management for common procedures (PC-D1) (18 months)

Diagnostic Tests:

• Make appropriate clinical decisions based on the results of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulations tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids (PC-E1) (12 months)

• Make appropriate clinical decisions based upon the results of more advanced diagnostic tests (PC-E2) (18 months)

Patient Management:

• Recognize situations with a need for urgent or emergent medical care, including life-threatening conditions (PC-F1) (6 months)

• Recognize when to seek additional guidance (PC-F2) (6 months)

• Provide appropriate preventive care and teach patient regarding self-care (PC-F3) (6 months)

• With minimal supervision, manage patients with common clinical disorders seen in the practice of inpatient and ambulatory general internal medicine (PC-F4) (12 months)

• With supervision, manage patients with common and complex clinical disorders seen in the practice of inpatient and ambulatory general internal medicine (PC-F5) (12 months)

• Initiate management and stabilize patients with emergent medical conditions (PC-F6) (12 months)

• Manage patients with conditions that require intensive care (PC-F7) (36 months)

• Independently manage patient with a broad spectrum of clinical disorders seen in the practice of general internal medicine (PC-F8) (36 months)

• Manage complex or rare medical conditions (PC-F9) (36 months)

• Customize care in the context of the patient’s preferences and overall health (PC-F10) (36 months)
Consultative Care:
- Provide specific, responsive consultation to other services (PC-G1) [24 months]
- Provide internal medicine consultation for patients with more complex clinical problems requiring detailed risk assessment (PC-G2) [36 months]

2) Medical Knowledge

Knowledge of Core Content:
- Understand the relevant pathophysiology and basic science for common medical conditions (MK-A1) [6 months]
- Demonstrate sufficient knowledge to diagnose and treat common conditions that require hospitalization (MK-A2) [12 months]
- Demonstrate sufficient knowledge to evaluate common ambulatory conditions (MK-A3) [18 months]
- Demonstrate sufficient knowledge to diagnose and treat undifferentiated and emergent conditions (MK-A4) [18 months]
- Demonstrate sufficient knowledge to provide preventive care (MK-A5) [18 months]
- Demonstrate sufficient knowledge to identify and treat medical conditions that require intensive care (MK-A6) [24 months]
- Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions (MK-A7) [36 months]
- Understand the relevant pathophysiology and basic science for uncommon or complex medical conditions (MK-A8) [36 months]
- Demonstrate sufficient knowledge of socio-behavioral sciences including but not limited to health care economics, medical ethics and medical education (MK-A9) [36 months]

Diagnostic Tests:
- Understand indications for and basic interpretation of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation studies, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids (MK-B1) [12 months]
- Understand indications for and has basic skills in interpreting more advanced diagnostic tests (MK-B2) [18 months]
- Understand prior probability and test performance characteristics (MK-B3) [18 months]

3) Practice-Based Learning and Improvement

Improve the Quality of Care for a Panel of Patients:
- Appreciate the responsibility to assess and improve care collectively for a panel of patients (PBLI-A1) [12 months]
- Perform or review audit of a panel of patients using standardized, disease-specific, and evidence-based criteria (PBLI-A2) [24 months]
- Reflect on audit compared with local or national benchmarks and explore possible explanations for deficiencies, including doctor-related, system-related, and patient-related factors (PBLI-A3) [24 months]
- Identify areas in resident's own practice and local system that can be changed to improve the processes and outcomes of care (PBLI-A4) [36 months]
- Engage in a quality improvement intervention (PBLI-A5) [36 months]

Ask Answerable Questions for Emerging Information Needs:
- Identify learning needs (clinical questions) as they emerge in patient care activities (PBLI-B1) [12 months]
• Classify and precisely articulate clinical questions (PBLI-B2)  
  [24 months]
• Develop a system to track, pursue, and reflect on clinical questions (PBLI-B3)  
  [24 months]

Acquires the Best Evidence:
• Access medical information resources to answer clinical questions and support decision making (PBLI-C1)  
  [12 months]
• Effectively and efficiently search NLM databases for original clinical research articles (PBLI-C2)  
  [12 months]
• Effectively and efficiently search evidence-based summary medical information resources (PBLI-C3)  
  [24 months]
• Appraise the quality of medical information resources and select among them based on the characteristics of the clinical question (PBLI-C4)  
  [36 months]

Appraises the Evidence for Validity and Usefulness:
• With assistance, appraise study design, conduct, and statistical analysis in clinical research papers (PBLI-D1)  
  [12 months]
• With assistance, appraise clinical guideline recommendations for bias (PBLI-D2)  
  [24 months]
• Independently appraise study design, conduct and statistical analysis in clinical research papers (PBLI-D3)  
  [36 months]
• Independently appraise clinical guideline recommendations for bias and cost-benefit considerations (PBLI-D4)  
  [36 months]

Applies the Evidence to Decision-Making for Individual Patients:
• Determine if clinical evidence can be generalized to an individual patient (PBLI-E1)  
  [12 months]
• Customize clinical evidence for an individual patient (PBLI-E2)  
  [24 months]
• Communicate risks and benefits to alternative to patients (PBLI-E3)  
  [36 months]
• Integrate clinical evidence, clinical context, and patient preferences into decision-making (PBLI-E4)  
  [36 months]

Improves Via Feedback:
• Respond willingly and productively to feedback from all members of the health care team including faculty, peer residents, students, nurses, allied health workers, patients and their advocates (PBLI-F1)  
  [12 months]
• Actively seek feedback from all members of the health care team (PBLI-F2)  
  [18 months]
• Calibrate self-assessment with feedback and other external data (PBLI-F3)  
  [24 months]
• Reflect on feedback in developing plans for improvement (PBLI-F4)  
  [24 months]

Improves Via Self-Assessment:
• Maintain awareness of the situation in the moment, and respond to meet situational needs (PBLI-G1)  
  [24 months]
• Reflect (in action) when surprised, applies new insights to future clinical scenarios, and reflects (on action) back on the process (PBLI-G2)  
  [36 months]

Participates in the Education of All Members of the Team:
• Actively participate in teaching conferences (PBLI-H1)  
  [12 months]
• Integrate teaching, feedback and evaluation with supervision of interns' and students' patient care (PBLI-H2)  
  [24 months]
• Take a leadership role in the education of all members of the health care team (PBLI-H3)  
  [36 months]

4) Interpersonal and Communications Skills

Communicate Effectively:
• Provide timely and comprehensive verbal and written communication to patients/advocates (ICS-A1)  
  [12 months]
• Effectively use verbal and nonverbal skills to create rapport with patients/families (ICS-A2)  
  [12 months]
• Use communication skills to build a therapeutic relationship (ICS-A3)  
  [12 months]
• Engage patients/advocates in shared decision making for uncomplicated diagnostic and therapeutic scenarios (ICS-A4) (24 months)
• Utilize patient centered educational strategies (ICS-A5) (24 months)
• Engage patient/advocates in shared decision-making for difficult, ambiguous or controversial scenarios (ICS-A6) (36 months)
• Appropriately counsel patients about the risks and benefits of tests and procedures highlighting cost awareness and resource allocation (ICS-A7) (36 months)
• Role model effective communication skills in challenging situations (ICS-A8) (36 months)

Intercultural Sensitivity:
• Effectively use an interpreter to engage patient in the clinical setting, including patient education (ICS-B1) (6 months)
• Demonstrate sensitivity to differences in patients including but not limited to race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious beliefs (ICS-B2) (12 months)
• Actively seek to understand patient differences and views and reflects this in respectful communication and shared decision-making with the patient and the healthcare team (ICS-B3) (30 months)

Transitions of Care:
• Effectively communicate with other caregivers in order to maintain appropriate continuity during transitions of care (ICS-C1) (12 months)
• Role model and teach effective communication with next caregivers during transitions of care (ICS-C2) (24 months)

Interprofessional team:
• Deliver appropriate, succinct, hypothesis-driven oral presentations (ICS-D1) (6 months)
• Effectively communicate plan of care to all members of the health care team (ICS-D2) (12 months)
• Engage in collaborative communication with all members of the health care team (ICS-D3) (30 months)

Consultation:
• Request consultative services in an effective manner (ICS-E1) (6 months)
• Clearly communicate the role of consultant to the patient, in support of the primary care relationship (ICS-E2) (12 months)
• Communicate consultative recommendations to the referring team in an effective manner (ICS-E3) (36 months)

Health Records:
• Provide legible, accurate, complete, and timely written communication that is congruent with medical standards (ICS-F1) (6 months)
• Ensure succinct, relevant and patient-specific written communication (ICS-F2) (24 months)

5) **Professionalism**

Adhere to Basic Ethical Principles:
• Document and report clinical information truthfully (P-A1) (1 month)
• Follow formal policies (P-A2) (1 month)
• Accept personal errors and honestly acknowledge them (P-A3) (6 months)
• Uphold ethical expectations of research and scholarly activity (P-A4) (36 months)

Demonstrate Compassion and Respect to Patients:
• Demonstrate empathy and compassion to all patients (P-B1) (3 months)
• Demonstrate a commitment to relieve pain and suffering (P-B2) (3 months)
• Provide support (physical, psychological, social and spiritual) for dying patients and their families (P-B3) (24 months)
• Provide leadership for a team that respects patient dignity and autonomy (P-B4) (24 months)
Provide Timely, Constructive Feedback to Colleagues:
- Communicate constructive feedback to other members of the health care team (P-C1) 
  (12 months)
- Recognize, respond to and report impairment in colleagues or substandard care via peer review process (P-C2) 
  (18 months)

Maintain Accessibility:
- Respond promptly and appropriately to clinical responsibilities including but not limited to calls and pages (P-D1) 
  (1 month)
- Carry out timely interactions with colleagues, patients, and their designated caregivers (P-D2) 
  (6 months)

Recognize Conflicts of Interest:
- Recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients (P-E1) 
  (6 months)
- Maintain ethical relationships with industry (P-E2) 
  (30 months)
- Recognize and manage subtler conflicts of interest (P-E3) 
  (30 months)

Demonstrate Personal Accountability:
- Dress and behave appropriately (P-F1) 
  (1 month)
- Maintain appropriate professional relationships with patients, families and staff (P-F2) 
  (1 month)
- Ensure prompt completion of clinical, administrative and curricular tasks (P-F3) 
  (6 months)
- Recognize and address personal, psychological, and physical limitations that may affect professional performance (P-F4) 
  (12 months)
- Recognize the scope of his/her abilities and ask for supervision and assistance appropriately (P-F5) 
  (12 months)
- Serve as a professional role model for more junior colleagues (e.g. medical students, interns) (P-F6) 
  (6 months)
- Recognize the need to assist colleagues in the provision of duties (P-F7) 
  (6 months)

Practice Individual Patient Advocacy:
- Recognize when it is necessary to advocate for individual patient needs (P-G1) 
  (6 months)
- Effectively advocate for individual patient needs (P-G2) 
  (30 months)

Comply with Public Health Policies:
- Recognize and take responsibility for situations where public health supersedes individual health (e.g. reportable infectious diseases) (P-H1) 
  (24 months)

Respect the Dignity, Culture, Beliefs, Values, and Opinions of the Patient:
- Treat patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age, or socioeconomic status (P-I1) 
  (1 month)
- Recognize and manage conflict when patient values differ from their own (P-I2) 
  (30 months)

Confidentiality:
- Maintain patient confidentiality (P-J1) 
  (1 month)
- Educate and hold others accountable for patient confidentiality (P-J2) 
  (18 months)

Recognize and Address Disparities in Health Care:
- Recognize that disparities exist in health care among populations and that they may impact care of the patient (P-K1) 
  (12 months)
- Embrace physicians' role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering (P-K2) 
  (36 months)
- Advocates for appropriate allocation of limited health care resources (P-K3) 
  (36 months)
6) **Systems-Based Practice**

Works Effectively within Multiple Health Delivery Systems:

- Understand unique roles and services provided by local health care delivery systems (SBP-A1)  
  
- Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, sub acute, acute, rehabilitation and skilled nursing (SBP-A2)  
  
- Negotiate patient-centered care among multiple care providers (SBP-A3)  
  
Works Effectively within an Interprofessional Team:

- Appreciate roles of a variety of health care providers, including but not limited to consultants, therapists, nurses, home care workers, pharmacists, and social workers (SBP-B1)  
  
- Work effectively as a member within the interprofessional team to ensure safe patient care (SBP-B2)  
  
- Consider alternative solutions provided by other teammates (SBP-B3)  
  
- Demonstrate how to manage the team by utilizing the skills and coordinating the activities of interprofessional team members (SBP-B4)  

Recognizes System Error and Advocates for System Improvement:

- Recognize health system forces that increase the risk for error including barriers to optimal care (SBP-C1)  
  
- Identify, reflect on, and learn from critical incidents such as near misses and preventable medical errors (SBP-C2)  
  
- Dialogue with care team members to identify risk for and prevention of medical error (SBP-C3)  
  
- Understand the mechanisms for analysis and correction of systems errors (SBP-C4)  
  
- Demonstrate ability to understand and engage in a system level quality improvement initiative (SBP-C5)  
  
- Partner with other healthcare team professionals to identify, propose improvement opportunities within the system (SBP-C6)  

Identifies Forces that Impact the Cost of Health Care and Advocates for Cost-Effective Care:

- Reflect awareness of common socio-economic barriers that impact patient care (SBP-D1)  
  
- Understand how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines (SBP-D2)  
  
- Identify the role of various health care stakeholders including providers, suppliers, financiers, purchasers and consumers and their varied impact on the cost of and access to health care (SBP-D3)  
  
- Understand coding and reimbursement principles (SBP-D4)  

Practices Cost-Effective Cares:

- Identify costs for common diagnostic or therapeutic tests (SBP-E1)  
  
- Minimize unnecessary care including tests, procedures, therapies and ambulatory or hospital encounters (SBP-E2)  
  
- Demonstrate the incorporation of cost-awareness principles into standard clinical judgments and decision-making (SBP-E3)  
  
- Demonstrate the incorporation of cost-awareness principles into complex clinical scenarios (SBP-E4)
APPENDIX C
Grand Rounds Preparation Guidelines/Grand Rounds Evaluation Form

Grand Rounds presentations are the end point of a scholarly project. They are a culmination of work that residents discover and prepare from multiple sources. If a physician can open a textbook and read the same material that is presented in Grand Rounds, the presentation is not scholarly work.

Residents should work with a faculty mentor who can assist them to ensure their presentations have rigorous and well-designed content meeting the high standards of a Grand Rounds presentation. A full-time or community faculty member should provide important guidance to residents as they develop their presentations. Residents are encouraged to identify a mentor for their presentations. If necessary, a mentor can be assigned to you.

The general Grand Rounds format is:

1. **Background**
   In the background, the resident should explain the reason (i.e., the rationale) that the presentation is being given. Specific cases are useful in framing the presentation. The presentation should include the relevance to general internists and resident’s daily practice and the significance to the population at large (prevalence, incidence, and cost to society).

2. **The questions**
   The resident should present the clinical question(s), which the Grand Rounds presentation will answer. The questions may be prompted by the specific case presented in the background. The clinical questions should be framed from an evidence-based approach. For example, topics on treatment should frame the question to include the specific exposure and outcome. An example is "Does […] specific drug or treatment […] increase/decrease […] specific outcome…?]? Topics on diagnosis should frame the question to include the specific diagnosis and the specific diagnostic test. An example is "What are the positive and negative likelihood ratios of a […] specific diagnostic test…] in diagnosing a […] disease…]?

3. **Methodology**
   The resident should describe the data gathering that was performed for the presentation including a description of the Medline search and MeSH headings that were used, textbooks that were used, and consultants queried.

4. **The body of the presentation**
   The resident should present the pertinent data in answering the question. Journal articles and book chapters with page numbers should be footnoted at the bottom of the slides.

   Important information that should be included in the presentation especially in discussing a particular disease entity includes: prevalence and incidence based on epidemiologic studies, risk factors for the disease based on case control and cohort studies (demonstrating an understanding of odds ratios and risk ratios), the likelihood ratios/sensitivity and specificity for diagnostic tests used in the work-up of the disease, and a review of the current literature about treatment options that would include numbers-needed-to-treat and a discussion of the confidence intervals. An evidence table should be part of most grand rounds.
5. **Referring to the patient**
   If the resident began the presentation with a particular patient, the data gathered from the body of the presentation should be applied to the particular patient involved. For instance, based on the patient's symptoms and signs, estimate pre-test probabilities of disease, apply the likelihood ratios of the given test characteristics to estimate the post-test probability of the disease, and discuss whether the therapies involved would be beneficial to your patient.

6. **Conclusion**
   The conclusion should state succinctly the answers to the questions raised earlier.

7. **Post-presentation, questions, and answers**
   The resident must leave 10 minutes open for discussion of the topic and allow the audience opportunity to ask questions. If the resident does not complete the presentation in the time allotted, the resident will be asked to stop so that questions may be asked.

6/16/14
The University of Kansas School of Medicine-Wichita
Grand Rounds Evaluation

Please circle the appropriate number for each item.

<table>
<thead>
<tr>
<th>QUESTION:</th>
<th>STRONGLY DISAGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Content of Presentation</td>
<td>1 2 3 4 5 N/A</td>
<td>1 2 3 4 5 N/A</td>
</tr>
<tr>
<td>a. Demonstrates the ability to convey why this is an important topic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Presented objectives that were important, clearly stated &amp; pertinent to IM residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Exhibited knowledge of appropriate basic epidemiological and/or statistical principle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Displayed an adequate bibliography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Provided a balanced presentation free of bias</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Delivery of Presentation</td>
<td>1 2 3 4 5 N/A</td>
<td>1 2 3 4 5 N/A</td>
</tr>
<tr>
<td>a. Displayed confidence and enthusiasm for the topic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Demonstrated the ability to be interesting and engaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Documented time management skills for the presentation and questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Exhibits the preparation to field questions adequately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Develops adequate audio visuals including handouts and/or slides</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL _____ 50 possible  Resident Score____

Please describe any suggestions to improve this presentation:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Evaluator: _________________________________

8/1/2014
APPENDIX D

Evaluation Forms

1. All Rotation/Peer/Self Assessment Evaluations - available to view at https://share.kumc.edu/SOM/wichita/IM/SiteAssets/AAEvaluationsbook.pdf
   • Completed on-line at www.new-innov.com

2. Patient Evaluation at KUSM-W Patient Care Clinic
   • Completed by selected patients approximately every six months

3. Mini Clinical Exam (CEX)
   • Completed in the Patient Care Clinic

4. Nursing Staff Evaluation at KUSM-W Patient Care Clinic
   • Completed by nursing staff approximately every six months

5. Resident Chart Audits (Practice Based Learning)
   • Completed each month when assigned to Med 1 service

6. Procedural Skills
   • Procedure cards available in office, clinic, or on website

7. Journal Club Article Evaluation
   • Forms provided at Journal Club and on-line at www.new-innov.com; at least 3 required per year

8. Journal Club Presentation Evaluation
   • Forms provided at Journal Club

9. Six Month and Annual Evaluation by Program Director
   • Completed at 6 Month and Annual Review

10. Final Evaluation by Program Director
    • Completed at End of Year Review

11. Problem Remediation Summary
    • Completed as necessary
## Out-Patient Clinic
### Patient Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your doctor give you a chance to explain the reasons for your visit?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Are you involved in decisions about your care?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Does your doctor look you in the eye when you talk, rather than at the chart or elsewhere?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Does your doctor explain why you need tests in a way that you can understand?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Does your doctor tell you how you will find out the results of your tests?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>6. After the tests are completed, does your doctor explain the results in a way that you can understand?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>7. Does your doctor explain the purpose and side effects of any prescribed medicine in a way you can understand?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Does your doctor explain what to do if problems or symptoms continue, get worse or come back?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Do you know how to contact your doctor or the doctor on call after hours?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Comments: 

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
### MINI-CEX - EVALUATION OF RESIDENT SKILLS

<table>
<thead>
<tr>
<th>History Taking</th>
<th>Physical Exam</th>
<th>Clinical Judgment, Counseling, Assessment &amp; Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+)</td>
<td>(-)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Gathering Skills</th>
<th>Physical Exam Skills</th>
<th>Counseling Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicited chief complaint</td>
<td>Efficient &amp; logical sequence of exam</td>
<td>Explained diagnosis, diagnostic possibilities</td>
</tr>
<tr>
<td>Characterized chief comp symptoms</td>
<td>Appropriate systems eval Identify system below</td>
<td>Explained etiology, progression, goals of therapy</td>
</tr>
<tr>
<td>Obtained relevant PMH</td>
<td>Identify system below</td>
<td>Explained the rationale for tests</td>
</tr>
<tr>
<td>Obtained relevant FH</td>
<td>Selectively ordered/performed diagnostic tests</td>
<td>Explains risk/benefits of tests &amp; treatment vs none</td>
</tr>
<tr>
<td>Obtained relevant SH</td>
<td>Complete exam of appropriate systems Identify system below</td>
<td>Gave pt feedback @ exam findings &amp; / or tests</td>
</tr>
<tr>
<td>Demonstrated organization</td>
<td></td>
<td>Obtained patient consent to treatment plan</td>
</tr>
<tr>
<td>Used open-ended questions</td>
<td></td>
<td>Educated patient regarding management</td>
</tr>
<tr>
<td>Listened w/o interruption</td>
<td></td>
<td>Gave written instructions to patient</td>
</tr>
<tr>
<td>Invited pt comments/concerns</td>
<td>Communication Skills</td>
<td>Practice - Based Learning</td>
</tr>
<tr>
<td>Repeated or clarified pt comments</td>
<td>Communication Skills</td>
<td>Clinical Judgment ➔ Assessment ➔ Plan</td>
</tr>
<tr>
<td>Encouraged question asking</td>
<td></td>
<td>Demonstrated appropriate clinical judgment</td>
</tr>
<tr>
<td>Used language that pt understands</td>
<td>Gave clear exam instructions to pt</td>
<td>Synthesized all data in assessment &amp; to develop plan</td>
</tr>
<tr>
<td>Made eye contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responded to pt affect &amp; non-verbal cues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Humanistic Behaviors</th>
<th>RIME Evaluation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(+)</td>
<td>(-)</td>
<td></td>
</tr>
<tr>
<td>Was courteous &amp; respectful</td>
<td>Used encouraging, supportive or empathic statements</td>
<td></td>
</tr>
<tr>
<td>Used encouraging, supportive or empathic statements</td>
<td>Conveyed a caring attitude</td>
<td></td>
</tr>
<tr>
<td>Conveyed a caring attitude</td>
<td>Was attentive to pt comfort / modesty</td>
<td></td>
</tr>
<tr>
<td>Was attentive to pt comfort / modesty</td>
<td>Was non-judgmental toward pt</td>
<td></td>
</tr>
<tr>
<td>Was non-judgmental toward pt</td>
<td>Established trust</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resident:</th>
<th>PGY-Level:</th>
<th>Evaluated by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporter</th>
<th>Interpreter</th>
<th>Manager</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th></th>
</tr>
</thead>
</table>

S:\Internal Medicine\department\RESIDENT\Procedures\Policy&ProcedureManual
**SUGGESTIONS FOR CONTINUED DEVELOPMENT OF SKILLS:**
(Provide resident with both written & verbal feedback)

<table>
<thead>
<tr>
<th>THE NEXT STEP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY TAKING SKILLS:</td>
<td></td>
</tr>
<tr>
<td>THE NEXT STEP</td>
<td></td>
</tr>
<tr>
<td>PHYSICAL EXAM SKILLS:</td>
<td></td>
</tr>
<tr>
<td>THE NEXT STEP</td>
<td></td>
</tr>
<tr>
<td>COUNSELING ASSESSING &amp; PLANNING</td>
<td></td>
</tr>
</tbody>
</table>

Verbal Feedback Session with Resident took place?    Yes    No

Attending Signature    __________________________

Resident Signature    __________________________
# NURSING STAFF
## EVALUATION OF RESIDENT PERFORMANCE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Never - - - - - - - - - - - - - - Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Does the resident treat the staff with respect?</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td><strong>Does the resident understand, support, utilize, and respect the role of nurses and other health care workers in the health care team?</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Does the resident respond promptly to pages?</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td><strong>Does the resident behave with compassion while performing procedures on patients (pelvic exams, injections, etc.)?</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Does the resident fill out required forms and complete dictation in a correct and timely manner?</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td><strong>Does the resident maintain organization of his/her mail and files for the clinic?</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Is there any particular feedback you believe this resident needs to receive?
Please comment in the space below. Both positive and constructive comments welcome.
The University of Kansas School of Medicine—Wichita  
Residency Program in Internal Medicine  
Resident Inpatient Chart Audit

Resident: ___________________________ Date of Review: _______________________
Patient initials and chart #: ___________________ Service: ________________________
Type of Document Reviewed: ___________________________ Attending: ________________________

- History & Physical
- Discharge Summary
- Progress Note
- Consultation
- Procedure Note

Please evaluate the sections that are relevant to the record in review. Cite specific examples of resident performance and include recommendations for improvement.

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate History for presenting problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate Physical exam documented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accurate Assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developed diagnostic plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developed therapeutic plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge summary concise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge summary clear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final diagnoses complete and fit findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D/C instructions given to patient</td>
<td>Diet</td>
<td>Activity</td>
<td>Meds</td>
</tr>
<tr>
<td>Follow/up visit scheduled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of communication with F/U MD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Knowledge</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differential diagnosis documented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpretation of exam and lab findings documented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates investigatory and analytic thinking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates knowledge appropriate to level of training</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal and Communication</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorough and complete</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicates with referral or primary care provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses SOAP format</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professionalism</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely completion of records</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Systems Based Practice</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides documentation to enable appropriate billing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses appropriate ICD codes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses appropriate E&amp;M codes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Made appropriate referral(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides cost-effective health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate use of lab, X-ray, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is there direct documentation of involvement by the supervisory resident in the care and management of this patient’s illness?  

Auditor’s Signature: ___________________________ Resident: ___________________________
Resident __________________________________________ Date ______________

Review the following procedural skills and identify those procedures performed acceptably under your supervision during the resident’s rotation on your service. Parentheses contain the minimum number of procedures requiring direct supervision before certification can be granted.

ABIM SKILLS REQUIRED FOR GRADUATION (indicate number of procedure(s) performed).
- Pap smear and Endocervical Culture (5)
- Drawing Venous Blood (5)
- Drawing Arterial Blood (Arterial puncture) (5)
- Placing a Peripheral Venous Line (5)

Other __________________________________________

Indication _______________________________________

Complications __________________________________
-------------------------------------------------
-------------------------------------------------

Supervisor’s Name (please print) ____________________

Supervisor's Signature __________________ Date __________

Return to KUSM-W, Department of Internal Medicine, Residency Office

S: Internal medicine/residents/procedures/resident procedure card.doc
WJS:lbf REV 6/30/13
KU School of Medicine-Wichita
Internal Medicine Residency Program
Journal Club
Article Evaluation

Reference

Research Question/Hypothesis

Type of Article
☐ Diagnostic Test ☐ Therapy ☐ Overview/Meta-analysis

Methods
☐ Prospective ☐ Randomized ☐ Cohort
☐ Retrospective ☐ Non-Randomized ☐ Case-Control
☐ Double-Blinded ☐ Interventional ☐ Other

Study Validity

Therapy
☐ Patients were assigned randomly.
☐ All patients were accounted for and attributed in the conclusions.
☐ Clinicians and study personnel were blinded to treatment.
☐ Study groups were similar at the start of the trial.
☐ Study groups were treated equally.

Diagnostic Test
☐ There was an independent, blind comparison with a reference standard.
☐ An appropriate spectrum of patients were sampled for whom the test will be applied.
☐ The results of the test being evaluated did not influence the decision to perform the reference standard.
☐ Methods were described to permit replication.

Overview
☐ The overview addressed a focused clinical question.
☐ Appropriate criteria were used to select articles for inclusion.
☐ It was unlikely that important, relevant articles were missed.
☐ Validity of included studies was included.
☐ Assessments of the studies was reproducible.
☐ Results were similar from study to study.
### Precision of Results

**2X2 Table**

<table>
<thead>
<tr>
<th>+ Disease/ Outcome</th>
<th>- Disease/ Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Exposure</td>
<td>a</td>
</tr>
<tr>
<td>- Exposure</td>
<td>c</td>
</tr>
<tr>
<td></td>
<td>b</td>
</tr>
<tr>
<td></td>
<td>d</td>
</tr>
<tr>
<td></td>
<td>a + b</td>
</tr>
<tr>
<td></td>
<td>c + d</td>
</tr>
</tbody>
</table>

### Therapy

<table>
<thead>
<tr>
<th>Relative Risk</th>
<th>Sensitivity</th>
<th>Relative Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\frac{a}{a+b}$</td>
<td>$\frac{a}{a+c}$</td>
<td>$\frac{a}{a+b}$</td>
</tr>
</tbody>
</table>

### Diagnostic Test

<table>
<thead>
<tr>
<th>Specificity</th>
<th>Relative Risk Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\frac{d}{b+d}$</td>
<td>100%-Relative Risk</td>
</tr>
</tbody>
</table>

### Overview

<table>
<thead>
<tr>
<th>Relative Risk Reduction</th>
<th>Likelihood Ratio (Positive)</th>
<th>Absolute Risk Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%-Relative Risk</td>
<td>$\frac{sensitivity}{(1-specificity)}$</td>
<td>$(c/[c+d]-(a/[a+b])$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pretest Probability</th>
<th>Number Needed to Treat</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\frac{a+c}{a+b+c+d}$</td>
<td>$\frac{1}{\text{Absolute Risk Reduction}}$</td>
</tr>
</tbody>
</table>

### Likelihood Ratio (Negative)

<table>
<thead>
<tr>
<th>Likelihood Ratio (Negative)</th>
<th>Absolute Risk Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>$(1-sensitivity)\cdot specificity$</td>
<td>$(c/[c+d]-(a/[a+b])$</td>
</tr>
</tbody>
</table>

### Number Needed to Treat

<table>
<thead>
<tr>
<th>$\frac{1}{\text{Absolute Risk Reduction}}$</th>
<th>Check applicable study characteristics</th>
</tr>
</thead>
</table>

### Study Results

- Pre-test Odds
  - $\frac{\text{Pre-test Probability}}{1-\text{Pre-test Probability}}$

- Post-test Odds
  - $\frac{\text{Pre-test Odds} \times \text{Likelihood Ratio}}{\text{Pre-test Probability}}$

- Post-test Probability
  - $\frac{\text{Post-test Odds}}{1+\text{Post-test Odds}}$
<table>
<thead>
<tr>
<th>Therapy</th>
<th>Diagnostic Test</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ The treatment effect was sufficiently large.</td>
<td>□ The likelihood ratio was presented or data were provided for calculation.</td>
<td>□ The overall results were precise.</td>
</tr>
<tr>
<td>□ The estimate of the treatment effect was precise.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Will the Results Help with Patient Care** Check applicable study characteristics

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Diagnostic Test</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ The results were applicable to my patients.</td>
<td>□ The reproducibility of the test result and its interpretation were satisfactory for my setting.</td>
<td>□ The results were applicable to my patients.</td>
</tr>
<tr>
<td>□ All clinically relevant outcomes were considered.</td>
<td>□ The results will change my management.</td>
<td>□ All clinically relevant outcomes were considered.</td>
</tr>
<tr>
<td>□ Benefits were worth the potential harms and costs.</td>
<td>□ Patients will be better off as a result of the test.</td>
<td>□ Benefits were worth the potential harms and costs.</td>
</tr>
</tbody>
</table>
### Journal Club
#### Presentation Evaluation

**Presenting Resident:**

**Date:** ____________________

**Journal Article:**

<table>
<thead>
<tr>
<th><strong>Presentation</strong></th>
<th><strong>The resident provided clearly stated objectives.</strong></th>
<th><strong>Strongly Disagree</strong></th>
<th><strong>Strongly Agree</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>The resident demonstrated appropriate understanding of basic epidemiological and/or statistical terms.</strong></th>
<th><strong>Strongly Disagree</strong></th>
<th><strong>Strongly Agree</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>The resident provided reasonable and succinct conclusions.</strong></th>
<th><strong>Strongly Disagree</strong></th>
<th><strong>Strongly Agree</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
The University of Kansas School of Medicine-Wichita
Residency Program in Internal Medicine
6 Month / Annual Evaluation Summary of Resident

Resident: «Resident»
PGY Level: «PGY»
EOY Review:

Please evaluate the resident’s performance for each component of clinical competence. Circle the rating which best describes the resident’s skills and abilities. Use as your standard the level of skill expected from the clearly satisfactory resident at this stage of training. Identify (by circling relevant phrases and/or providing separate comment on the reverse side) strengths and weaknesses you have observed. Occasionally, in your role as the attending physician you may be concerned about a resident’s performance but have incomplete or inconclusive information to support a rating of marginal or unsatisfactory. In this case you should signal that certain components of the resident’s clinical competence may “need attention”, a nonjudgmental category included on the evaluation form to encourage closer review of performance by the Program Director and future evaluators. Be as specific as possible, including reports of critical incidents. Global adjectives or remarks, such as “good resident”, do not provide as meaningful feedback to the resident as specific comments.

1. **Patient Care**

   **Unsatisfactory**
   
   1  2  3
   
   **Satisfactory**
   
   4  5  6
   
   **Superior**
   
   7  8  9

   Pedestrian diagnostic ability. Over reliance on tests on procedures. Misses major problems. Unable to establish priorities. Incomplete therapeutic plans.

   □ Needs attention
   □ Insufficient contact to judge

   Identifies all the patient problems. Interrelates abnormal findings with altered physiology. Establishes sensible differential diagnoses. Provides orderly succession of testing and therapeutic recommendations. Educates patients and families. Provides high quality, appropriate cost effective and comprehensive acute and chronic care.

   □ Needs attention
   □ Insufficient contact to judge

   a. **Medical Interviewing**

      **Unsatisfactory**
      
      1  2  3
      
      **Satisfactory**
      
      4  5  6
      
      **Superior**
      
      7  8  9

      Often incomplete, superficial, by rote, and not directed to patient’s problems.

      □ Needs attention
      □ Insufficient contact to judge

      Always precise, logical, thorough, reliable, purposeful, and efficient. Establishes a broad base of information about the patient.

   b. **Physical Examination**

      **Unsatisfactory**
      
      1  2  3
      
      **Satisfactory**
      
      4  5  6
      
      **Superior**
      
      7  8  9

      Often incomplete, inaccurate, cursory, non-directed, insensitive, awkward, or unreliable.

      □ Needs attention
      □ Insufficient contact to judge

      Complete, accurate, directed toward patient’s problems. Properly sequenced. Elicits subtle findings.

   c. **Procedural Skills**

      **Unsatisfactory**
      
      1  2  3
      
      **Satisfactory**
      
      4  5  6
      
      **Superior**
      
      7  8  9

      Inept. Frequent disregard for risk to the patient and patient’s anxiety and comfort.

      □ Needs attention
      □ Insufficient contact to judge

      Always proficient. Minimizes risk and discomfort to patients. Provides proper explanation of purpose of procedure.

2. **Medical Knowledge**

   **Unsatisfactory**
   
   1  2  3
   
   **Satisfactory**
   
   4  5  6
   
   **Superior**
   
   7  8  9

   Limited knowledge of basic and clinical sciences; minimal interest in learning; does not understand complex relationships, mechanisms of disease.

   □ Needs attention
   □ Insufficient contact to judge

   Demonstrated an in-depth understanding of the basic mechanisms of human biology, and the application of current knowledge to practice, by the integration of pathophysiologic processes into the diagnosis, treatment and management of clinical disorders.
3. **Practice-Based Learning and Improvement**

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
<th>Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>

Fails to perform self-evaluation; lacks insight, initiative; resists or ignores feedback; fails to use information technology to enhance patient care or pursue self improvement.

☐ Needs attention

☐ Insufficient contact to judge

Constantly evaluates own performance, incorporates feedback into improvement activities; effectively uses technology to manage information for patient care and self improvement.

4. **Interpersonal and Communication Skills**

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
<th>Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>

Lacks appropriate integrity, respect, compassion, and empathy. Abuses trust and demonstrates unreliability. Frequently displays insensitivity and intolerance of patient’s need for comfort and encouragement. Does not appreciate patient’s perception of illness and preferences. Poor rapport with patients and families.

☐ Needs attention

☐ Insufficient contact to judge

Always demonstrates integrity, respect, compassion, and empathy for patients. Establishes trust. Primary concern is for the patient’s welfare. Maintains credibility, excellent rapport with patients and families, and respects patient’s need for information.

5. **Professionalism**

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
<th>Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>

Frequently irresponsible and uncommitted. Ineffective communication. Disruptive and disrespectful to other health care professionals. Shows disdain for professional colleagues. Records frequently tardy and illegible, although, complete and accurate.

☐ Needs attention

☐ Insufficient contact to judge

Enthusiastic. Responsive, reliable, committed, cooperative, and respectful. Provides effective communication. Shows regard for opinions and skills of professional colleagues. Displays initiative and provides leadership. Records are legible and timely.

6. **Systems-Based Practice**

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
<th>Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td>4 5 6</td>
<td>7 8 9</td>
</tr>
</tbody>
</table>

Unable to assess/mobilize outside resources; resists efforts to improve systems of care; does not use systematic approaches to reduce error and improve patient care.

☐ Needs attention

☐ Insufficient contact to judge

Effectively accesses/utilizes outside resources approaches to reduce errors and improve patient care; enthusiastically assists in developing systems improvement.

7. **Overall Clinical Competence as a Specialist in Internal Medicine**

This rating represents your assessment of the resident's overall performance during this year of training:

- ☐ Superior: Far exceeds reasonable expectations
- ☐ Satisfactory: Always meets and occasionally exceeds reasonable expectations
- ☐ Marginal: Meets some expectations but occasionally falls short
- ☐ Unsatisfactory: Consistently falls short of reasonable expectations

Please provide comments about the trainee’s clinical performance:

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Residents’ Signature _________________________________  Evaluator’s Signature __________________________    _________

Date
The University of Kansas School of Medicine-Wichita
Residency Program in Internal Medicine
Final Evaluation of Resident

Please check the appropriate categories:

**Status in the Program**

- [ ] The resident has completed this year of training satisfactorily.
- [ ] I verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.
- [ ] The resident has some unresolved problems. I am deferring decision on this year of training until October 1st. At that time, I will submit a supplemental evaluation of his/her performance (satisfactory or unsatisfactory) for that year.
- [ ] The resident has completed this year of training satisfactorily. At his/her request, the resident will not be re-appointed in the program.
- [ ] The resident has been terminated from the program because of his/her unsatisfactory performance. (Please complete the information below, describe problem(s) on reverse side).

**Evaluation of Overall Clinical Competence**

- [ ] Superior
- [ ] Satisfactory
- [ ] Marginal (Please complete Problem/Remediation Summary on the reverse side)
- [ ] Unsatisfactory (Please complete Problem/Remediation Summary on the reverse side)

If the resident is not re-appointed or is terminated, please provide follow-up information (e.g., new position, current address):

________________________________________________________________________________________
________________________________________________________________________________________

Did you discuss this summary with the resident?  [ ] Yes  [  ] No

Advisor/Evaluator Name (print) & Initial  ____________________________  Date ____________________________

Resident’s Signature  ____________________________  Date ____________________________

Program Director
Problem/Remediation Summary

Problem(s)

___________________________________________________________________________________________________
___________________________________________________________________________________________________

Remediation

Describe type of remediation undertaken (e.g., increased supervision, repeat rotation, psychiatric consultation):

___________________________________________________________________________________________________
___________________________________________________________________________________________________

Person(s) responsible for determining type of remediation (please check appropriate box):

☐ Program Director  ☐ Evaluation Committee  ☐ Faculty Advisor  ☐ Other

Person(s) responsible for implementing remediation:

☐ Program Director  ☐ Evaluation Committee  ☐ Faculty Advisor  ☐ Other

Time allotted for remediation:  ______________________________________

Start Date:  ______________________ End Date:  ______________________

Outcome (Check only one): 

________ Successful resolution of problem
________ Unresponsive to remediation
________ Needs more/different remediation
________ Termination

(Person(s) responsible for assessing outcome)

________ Program Director
________ Evaluation Committee
________ Faculty advisor
________ Other

Outcome (Check only one): 

________ No further remediation required
________ Continuation of current remediation
________ New plan for remediation
________ Termination

(Person(s) responsible for assessing outcome)

________ Program Director
________ Evaluation Committee
________ Faculty advisor
________ Other
APPENDIX E

Wichita Center For Graduate Medical Education
Grievance Procedure Guidelines For Residents

Residents employed by the Wichita Center for Graduate Medical Education are entitled to participate in the Grievance Procedure in the event an Adverse Action concerning residency status is taken. According to the Grievance Procedure Guidelines adopted by the Board of Directors of the Wichita Center for Graduate Medical Education, and explained in the following sections, an Adverse Action occurs when (1) a resident is placed on probation, (2) WCGME elects not to renew the agreement, (3) a resident is dismissed from a residency training program, or (4) any action is taken that threatens a resident’s intended career development. If any action is taken, residents are entitled to a hearing as explained below.

The Grievance Procedure is a method by which an impartial committee reviews the facts presented during a hearing to ensure that established procedures have been followed and that the procedures achieved the goals of fairness and accuracy. The committee has the authority to affirm the action, reverse the action, impose probation or dismiss the resident.

A resident's salary will continue, during the time they are exercising the Grievance Procedure rights, by requesting and proceeding with a hearing.

I. Notice of Adverse Action

A resident against whom adverse action has been taken shall be given written notice of the intended adverse action from the Program Director or their designee. The written notice shall include a concise statement of the resident's alleged acts or omissions or other reasons for the adverse action. The notice shall be given to the resident either by sending a copy of the notice to the resident by certified mail (return receipt requested), or by hand-delivering a copy to the resident and, if possible, obtaining the resident's signed receipt for the notice. If the resident refuses to sign the hand-delivered receipt, then such refusal shall be considered as an acknowledgment of delivery and noted on the receipt.

A copy of the notice shall also be given to the Chief Operating Officer of The Wichita Center for Graduate Medical Education.

II. Request for Hearing

A resident shall have ten (10) weekdays following receipt of such notice to file a written request for a hearing. Such request shall be delivered to the Chief Operating Officer of the Wichita Center for Graduate Medical Education, or designee, either in person or by certified or registered mail.

III. Waiver by Failure to Request a Hearing

A resident who fails to request a hearing within the time and in the manner specified waives any right to such hearing and to any review to which he/she might otherwise have been entitled.

IV. Notice of Time and Place of Hearing
Upon the receipt of a request for a hearing, the Chief Operating Officer of the Wichita Center for Graduate Medical Education, or designee, shall appoint a Hearing Committee and shall schedule and arrange for a hearing. The hearing shall occur within seven (7) to fourteen (14) weekdays from the date of receipt of the request for hearing. At least five (5) weekdays prior to the hearing, the Chief Operating Officer of the Wichita Center for Graduate Medical Education, or designee, shall provide the resident and the Program Director notice in writing of the time, place, date and membership of the hearing committee for the hearing. The Notice of Hearing may be given in person or by certified or registered mail. If given in writing, a receipt will be signed. If either party refuses to sign the hand-delivered receipt, then such refusal shall be considered as an acknowledgment of delivery and noted on the receipt. Notice of the hearing shall also include a list of the members of the Hearing Committee.

Within two weekdays of receipt of the Notice of Hearing, either party may note their objection, if any, to any Hearing Committee member on the grounds of bias or prejudice. The objection must be explained concisely in writing and given to the Chief Operating Officer, or designee, not later than noon on the date designated in the Notice of Hearing. The Chief Operating Officer, or designee, shall deliver the objections to the Chair of the Hearing Committee, who will have two weekdays to decide if the objection has any validity. If the Chair decides that the objection is not valid, the decision will be provided, in writing, to both parties, within two weekdays after the objection is made. The decision will be delivered in person or by certified or registered mail. If delivered in writing, a receipt will be signed. If either party refuses to sign the hand-delivered receipt, then such refusal shall be considered as an acknowledgment of delivery and noted on the receipt. If the Chair decides that the objection is valid, then the Hearing Committee member shall be removed and the Chief Operating Officer, or designee, shall appoint a substitute and provide notice of the substitution to both parties. If either party objects to the presence of the Chair, the Chief Operating Officer, or designee, shall designate another committee member to rule on the objection in the same manner as explained previously. The opportunity to object to a committee member as biased or prejudiced, and the ruling on that objection, shall not delay the scheduled hearing.

The Program Director and the resident shall exchange evidence which each intends to present at the hearing at least two (2) weekdays prior to the scheduled hearing. The evidence shall be delivered to the Chief Operating Officer no later than noon on the date designated in the Notice of Hearing, who shall then deliver it to each party. Evidence includes lists of witnesses and copies of documents or any other item that will be presented to the Hearing Committee for its consideration.

V. Statement of Charges
The Notice of Hearing, required by the preceding section, shall contain a copy of the notice of adverse action as described in Section 2.

VI. Appointment of Hearing Committee
The Hearing Committee shall be composed of five (5) persons and shall be appointed by the Chief Operating Officer, or designee, to include: 1. Associate Dean for Graduate Medical Education, or designee, who will serve as Chair, 2. A Program Director from a non-affected residency, 3. A member of the faculty from a non-affected residency, 4. A management representative from a member of The Wichita Center for Graduate Medical Education, which may include, but not be limited to, the Medical Education Director or the Vice President for Medical Staff Affairs, and 5. A resident from a non-affected residency program. No member of the committee shall be personally involved in the controversy described in the Statement of Charges. Attorneys are not allowed to attend Grievance Procedure hearings. The Chief Operating Officer, or designee, shall be in attendance at the hearing as an impartial observer.
VII. **Personal Presence**

The presence of the resident who requested the hearing shall be required. Any resident who fails, without cause, to appear and proceed, or who appears but refuses to proceed in accordance with these Grievance Procedures, at such hearing shall be deemed to have waived his/her rights in the same manner as if no request for hearing had been made.

The presence of the Program Director who initiated the proceedings giving rise to the hearing shall be required. If the Program Director fails, without cause, to appear and proceed at such hearing, the resident's position shall be adopted as if no action had been taken and any probationary terms already in place shall be removed.

VIII. **Presiding Officer**

The Chair of the Hearing Committee shall be the Presiding Officer and shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be responsible for enforcing and conducting the order of procedure during the hearing and shall make all rulings on matters of procedure or the admissibility of evidence. The Presiding Officer does not have a vote during deliberations unless to break a tie vote of the Hearing Committee members.

IX. **Opportunity to be Heard**

Both the resident and the Program Director shall be given an equal opportunity to be heard for such amounts of time as deemed fair and reasonable by the presiding officer. The Program Director and resident shall also be given the opportunity for a brief rebuttal. The Program Director’s case shall be presented first and shall be followed by the resident’s response. The Program Director shall then be given an opportunity for rebuttal followed by the resident’s rebuttal.

Both parties shall be present for the other side’s presentation but shall not be allowed to interrupt the opposing party’s presentation.

The parties will present their positions by a narrative format, which can be supplemented by questions and answers.

Witnesses will be present in the hearing room only during the time of their testimony or presentation. Each party may question the other party and their witnesses. Members of the committee may question the parties and their witnesses.

Formal rules of evidence are not followed; however, parties are cautioned to avoid only hearsay evidence during their presentations.

Any evidence that each party wants the committee to consider shall be designated as an exhibit, marked with an exhibit sticker, and referred to in their presentation of the case. Any evidence that has been previously exchanged between the parties that has not been referred to by either party as an exhibit in their case shall not be considered by the Hearing Committee.

X. **Record of Hearing**

A record of the hearing shall be kept. The Chief Operating Officer, or designee, shall select the method to be used for making the record such as a court reporter, electronic recording unit, detailed transcription or minutes of the proceedings. The deliberations of the Hearing Committee will not be recorded or
transcribed. The Wichita Center for Graduate Medical Education shall pay any costs for recording the hearing, but the party which requests a transcript shall be responsible for the costs of the transcription of the hearing.

XI. **Deliberations and the Hearing Committee Report**

Deliberations of the Hearing Committee shall be scheduled by the Presiding Officer according to the Committee members’ schedules. The final decision of the Hearing Committee shall be decided by a majority vote. The vote may be taken by voice or in writing.

Within five (5) weekdays after final deliberation of the hearing, the Hearing Committee shall make a written report of its findings and recommendations and shall forward them to the director of the residency program, to the resident in question and to the Chief Operating Officer, or designee. The written report may be delivered in person or by certified or registered mail. If delivered in person, a receipt will be signed. If any party refuses to sign the hand-delivered receipt, then such refusal shall be considered as an acknowledgment of delivery and noted on the receipt.

The committee may decide to:

a. Affirm the decision of the Program Director

b. Overrule the decision of the Program Director

c. Set or modify the probationary status for the resident. Any probationary action, which is either approved or determined by the Hearing Committee, shall have a definite time limit and shall have requirements, which are reasonable in light of the circumstances to which they respond. The time limit and requirements shall be in writing.

d. Dismiss the resident, which action shall take effect on the date stated in the Notice of Adverse Action or immediately.

The decision shall be immediately effective and appropriate action shall be promptly implemented. The decision shall be final and cannot be appealed through any person or entity affiliated with the Wichita Center for Graduate Medical Education.

XII. **Resident Compensation**

A resident shall continue to draw his/her salary according to the agreement until completion of the Grievance Procedure. If the resident physician’s recommended termination or non-renewal of agreement is upheld by the Hearing Committee, continued compensation will be made in keeping with terms of the Wichita Center for Graduate Medical Education employment agreement.

This agreement states that termination of salary and benefits will occur thirty (30) days after written notice of dismissal is provided to the resident or the date on which the due process hearing panel upholds the notice of dismissal, whichever date is later.
APPENDIX F
Excessive Census Plan

In the event that the Med I ward services reaches RRC limits for the number of patients for which residents can admit and or provide continuing care, the following contingency plan will be implemented.

At WMC and VC:

1. Either the Med I attending or one of the Med I faculty not attending at the time will assume care of any additional patients or divert patients to another physician.
2. The Med I attending may, at his/her discretion, direct the ER to divert new admissions to other physicians until the census is below the maximum threshold.
3. The Med I attending may perform consults without involving the resident team members at all.

Hospital____________________________________
DATE______________________________________
ATTENDING:________________________________
SR. RESIDENT:________________________________
JR. RESIDENT:________________________________
TOTAL PATIENT CENSUS #:_____________________

Patients supervised by Attending:

#1__________________________________________

#2__________________________________________

#3__________________________________________

#4__________________________________________

#5__________________________________________
APPENDIX G

Residency Administrative Forms

1. Residents Leave Request
2. Resident Moonlighting Request
3. Moonlighting Insurance Form & Salary Advance Form
4. Resident Locum Tenens Request
5. Educational Allowance Reimbursement Form
6. Rotation Request Form
Internal Medicine
Resident Leave Request

Name: ___________________________ Date: _____________

Dates of Absence: From: ______________ Through: ______________

Reason:
Vacation ☐ *Educational Leave ☐ Sick ☐
Bereavement Leave ☐ Fellowship ☐

*If educational leave you must attach conference material

► Rotation: ___________________________
  Attending Signature: ___________________________

► Clinic and Patient Coverage: ___________________________
  Covering Resident’s Signature: ___________________________

► Scheduled for Back-Up Coverage: Yes ☐ No ☐
  If yes, identify a resident to cover: ___________________________
  Covering Resident’s Signature: ___________________________

Resident Signature: ___________________________

Department Approval: ___________________________

Office Use Only
Request received 45 days prior to month of leave: Yes ☐ No ☐
Resident Notified ☐ _________
Clinic Notified ☐ _________
Call/Chief Notified ☐ _________
Database ☐ _________
RESIDENT MOONLIGHTING REQUEST

*All moonlighting must be counted towards duty hours.
*Only residents at PGY-2 level or above and those who have a full and unrestricted Kansas license may moonlight.
*All requests for moonlighting privileges must be submitted to the Program Director’s office and approved prior to the moonlighting activity.
*Residents with a J-1 Visa are not permitted to moonlight.

I request approval to participate in the moonlighting activity identified below. I acknowledge that it constitutes an extracurricular activity not related to my KUSM-W residency program; that I will be serving as a free agent entirely responsible for my professional activities; that this moonlighting activity will not be covered by my state-provided professional liability insurance; and that I must document the existence of current professional liability insurance with limits of not less than $1,000,000/$3,000,000 that will cover the activity.

Resident’s Name: _____________________________________________________________

Residency Program: ___________________________ PGY-Level: __ __

Kansas License #: ___________________________ Expiration Date

DEA Registration #: ___________________________ Expiration Date ____________

Moonlighting Insurance: (Copy of Certificate of Insurance must be attached to the copy of this form going to the WCGME Office.)

Policy Number: ___________________________ Effective Dates ____________ to ____________

Location of Moonlighting Activity:

Month(s) and Exact Days (if known): _____________________________________________

Time Period Approved for Moonlighting: From ____________ To ____________

(Signed) (Date)

(Approved) (Program Director) (Date) **********:***********

FOLLOWING APPROVAL:

White copy: Program Director
Yellow copy: WCGME (Must include Certificate of Insurance) Pink copy:
Resident
REQUEST FOR SALARY ADVANCE

MOONLIGHTING INSURANCE

I hereby request a salary advance of $ _______________ to cover the cost of the annual premium (invoice attached) for professional liability insurance required for me to engage in moonlighting activities. I hereby authorize WCGME to withhold the sum of $ ______________ from each of my next ____________ payroll deposits in order to repay this advance.

In the event I should terminate my employment with WCGME, I understand that the unpaid portion of this salary advance is payable in full within a period of 30 days. I also understand that, in the event the professional liability insurance policy is cancelled and a portion of the premium is refunded, the unpaid balance of the salary advance is payable in full within a period of 30 days.

My current contract:

Starting date: _______________

Ending date: _______________

______________________________          _________________________
   (Resident’s signature)                                                                (Date)

_____________________________
   (Resident’s printed name)

Approved by: ___________________________        _____________
   (Program Director’s Signature)               (Date)

Approved by:   _______________________________________
   (Chief Operating Officer)                                                            (Date)

WCGME

Check No:   ________________     issued:   _______________
   (Date)

Following approval:

White copy:       WCGME Office
Yellow copy:  Accountant
Pink copy:      Resident

8/98
RESIDENT LOCUM TENENS REQUEST
(To be submitted no less than 2 weeks prior to planned activity)

1. Approval is requested for ___________________________   ________________ to
   (Name of resident)                       (PGY- Level)
   participate in a locum tenens activity (for compensation) during time that he/she is not required to participate in
   his/her residency program sponsored by the UKSM-W.

2. This locum tenens will occur for:

   Name of Physician                  Location of Physician's office
   clinic or hospital                   Date(s)            Time(s)

3. Reason for physician's absence (i.e. illness, vacation, CME, etc.)

   ___________________________________________________________________________________

4. Reason why resident coverage via locum tenens is more appropriate than coverage via another community
   physician. (use a separate sheet if necessary)

   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

5. The resident has a full license issued by the Kansas State Board of Healing Arts and has an individual DEA
   registration number.

   License # __________________ DEA registration # and expiration date ________________________

6. As Program Director, I recommend that this activity be covered by the resident's professional liability insurance
   provided via the State of Kansas.

   Program Director's Signature   Date

7. I request permission to participate in the locum tenens activity identified above. I understand that it constitutes an
   extracurricular activity falling outside the confines of my formal residency program but that, if approved, it is to
   be covered by my state-provided professional liability insurance.

   _________________________________ _________________________
   Resident's signature             Date

FORWARD ALL COPIES TO:
Wichita Center for
Graduate Medical Education
1010 N. Kansas
Wichita, KS 67214-3199

Approved by:

________________________    ______________ ________________________    _____________
Chief Operating Officer                      Date Executive Vice Chancellor                 Date

Following Approval:  white copy: GME  yellow copy: Program Director  pink copy: Resident
WICHITA CENTER FOR GRADUATE MEDICAL EDUCATION
EDUCATION ALLOWANCE REIMBURSEMENT
(Purchase of Educational Material)

DATE: __________________

NAME: ___________________ PROGRAM: _______________________

Please complete the following:

<table>
<thead>
<tr>
<th>ITEMS PURCHASED</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL

Please attach a copy of your receipt

Resident’s Signature

Program Director’s Signature
(Approval)

Send to: WCGME
1010 N. Kansas
Wichita, KS 67214-3199

White copy: WCGME
Yellow copy: Departmental Office
# RESIDENT ROTATION CHANGE FORM

**RESIDENT NAME:**

**DATE SUBMITTED:**

**REASON FOR CHANGE:**
(must be valid educational reason)

<table>
<thead>
<tr>
<th>Block</th>
<th>Previous Rotation</th>
<th>Previous Attending</th>
<th>Newly Requested Rotation</th>
<th>Newly Requested Attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Staff Notes:**

---

C:\Users\jking11\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\IPXMGCWY\AA_Policy Procedure Manual 14-15.doc
# APPENDIX I

## PRACTICE BASED LEARNING

### Quality improvement

Our QI methods are based on Six Sigma as implemented by [Intermountain Health Care](http://sumsearch.org/quality/). Rather than teach a PDSA cycle, we will learn the **DMAIC** cycle (DMAIC is pronounced as "duh-may-ick"). Instructions are at [http://sumsearch.org/quality/](http://sumsearch.org/quality/).

Teams of residents, based on their block assignments, will address a QI project that is important to any of the Institute for Health Improvement triple aims (quality, cost, experience) of health care. The teams work together over the academic year and then present their results in May.

### The goals of this experience are...

<table>
<thead>
<tr>
<th>QI Objectives</th>
<th>Related ACGME Sub-Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Student will assess the health status of populations using available data (e.g., error reporting, public health surveillance data, vital statistics, registries, surveys, electronic health records and health plan claims data).</td>
<td>MK-1, MK-3, P-1, PBL-3, SBP-4, SBP-1, SBP-5</td>
</tr>
<tr>
<td>2. Appraise the quality of the evidence of peer reviewed medical and public health literature and its implications at patient- and population- levels.</td>
<td>PC-5, MK-1, MK-2, MK-3</td>
</tr>
<tr>
<td>3. Identify institutional and community assets and resources to improve the health of individuals and populations.</td>
<td>SBP-2, SBP-5</td>
</tr>
<tr>
<td>4. Identify and use methods to improve medical care and population health (e.g. practice-based learning and quality improvement)</td>
<td>PC-5, PBL-1, PBL-2, PBL-3, PBL-4, ICS-1, P-1, SBP-1, SBP-4, SBP-5</td>
</tr>
<tr>
<td>5. Student will understand the critical role of physician leadership and teamwork in influencing the quality improvement change process</td>
<td>PBL-2, PBL-3, PBL-4, SBP-1, SBP-5, P-1, P-4</td>
</tr>
</tbody>
</table>
APPENDIX J

Handoff Process – VC, VAMC, WMC

WESLEY MEDICAL CENTER

1. **WHAT:** Face to face exchange of patient information to include a written portion (template) and opportunity for questions.

2. **WHERE:** 4th Floor, Crow’s Nest (IM library) This is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

3. **HOW:** Use of a printed template, which was adapted from the mnemonic “ANTICipate” (see articles and process map attached) will be given to the receiving resident. If information is being passed so is a template card.

End-of-Rotation Handoff

1. **WHO:** Day PGY-1, PGY-3 and Attending going off service to respective Day PGY-1, PGY-3 coming onto service

2. **WHEN:** 4:00 or 5:00 p.m. on last day of service. This part is flexible.

Every day Morning Handoff

1. **WHO:** Night PGY-2 (Night Float) or Weekend on call Sr. handing off to Day PGY-3 (or On-Call Senior PGY-2 on weekends that 3rd yr. is off)

2. **WHEN:** 6:00-6:30 a.m. This is flexible.

   *Med I attending may drop by unannounced occasionally to evaluate the quality of handoff*

Friday Evening Handoff Pre-weekend (that 3rd yr. is off)

1. **WHO:** Med I PGY-3 to Senior coming to call on Saturday

2. **WHEN:** After 5:00 p.m. on Friday afternoon. This is flexible.

Saturday Evening Handoff During Weekend (that 3rd year is off)

1. **WHO:** Saturday on-call senior to Sunday on-call senior

2. **WHEN:** 6:00-7:00 a.m. on Sunday morning. This is flexible.

Sunday Evening Handoff Post-Weekend (that 3rd year is off)

1. **WHO:** On-call senior to Med I PGY 3

2. **WHEN:** 5:00-6:00 p.m. This is flexible.
Wesley Handoff Flowchart

**Weekdays**

Legend
- ○ Start and End of a process
- △ Task to perform
- □ Steps in the process

3rd yr senior on days
1st yr intern on days
2nd yr senior on call
1st yr on call

3 and 1 review pt's and note any pts that may need to be evaluated by NF overnight.

3 reviews pts with attending for updates of dismissal and unaccomplished tasks

3 check-out to NF @ 5pm (+/- intern on call) with code pager transfer and possible current pt's needing re-evaluated or task to complete (w/ Card)

NF check outs new patients with attending

Task performed with cards updated, 3 +/- attending notified of significant changes

NF and 3 have face to face checkout on new admissions with handoff cards given the following morning. Also update from NF to 3 for performed tasks

OC1 and NF meet at 8:30-9:00 p.m. to update NF on changes to any new admissions. NF rounds on new admissions and OC1 leaves.

NF and OC1 discuss patient plan and OC1 takes calls on the new admission until 9 PM

3 rounds on new pts and pages NF with any specific questions

3 uses handoff cards for presentations on rounds. Then gives cards to 1's when patient assigned who will then return card to library box when finished

C:sers\jking11\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\IPXMGCWY\AA_Policy Procedure Manual 14-15.doc
If 3 is on call for weekend then 3 reviews patients with attending for updates of dismissal and unaccomplished tasks after rounds *Please see below if 3 is off for weekend

Legend

○ - Start and End of a process
△ - Task to perform
□ - Steps in the process

3rd yr senior on days
1’s 1st yr interns on days
NF 2nd yr senior on call
OC1 1st yr on call
OCS-Sa 2nd or 3rd yr senior on call on Saturday
OCS-Su 2nd or 3rd yr senior on call on Sunday

3 checks out to OCS-Sa (or NF if holiday falls on a weekday) with update of pt census and possible current pt’s needing re-evaluated or task to complete (w/ Card)

Task performed with cards updated, 3 +/- attending notified of significant changes

OCS-Sa check outs new patients with attending

OC1 and OCS-Sa meet at 8:30-9:00 p.m. to update OCS-Sa on changes to new admissions. OCS-Sa rounds on new admissions and OC1 leaves

OCS-Sa and OC1 discuss patient plan and OC1 takes calls on the new admissions until 9 PM

3 or current OCS uses handoff cards for presentations on rounds and then gives cards to 1’s when patient assigned who will then return card to library box when finished.

3 or current OCS rounds on new pts and pages previous OCS with any specific questions

OCS-Sa and 3 have face to face checkout on new admissions with handoff cards given. Also update from OCS-Sa to 3 for performed tasks

*If 3 is off for weekend then 3 will check out to NF who will in turn check out to OCS-Sa (on call senior Saturday) with admissions and team updates. OCS-Sa will see patients that NF admitted overnight and round with Med I team to help with any intern issues. OCS-Sa will then handoff to Med I interns and continue admissions with OC1. The following day, OCS-Sa will hand off to OCS-Su (on call senior Sunday) and the same process happens all over again whereby OCS-Su will round with the Med I team and then continue admissions with OC1 after handing off to Med I interns post rounds.
VC Handoff Flowchart

Weekdays

Legend

- Start and End of a process
- Task to perform
- Steps in the process

3 3rd yr senior on days
1 1st yr intern on days
NFS Night Float Senior (3rd yr.)
NFJ Night Float Junior (1st yr.)

3's of both teams discuss sick patients/task and pending transfers before check out utilizing handoff cards (If a 3 is in clinic, the 1's of his team should discuss with the other 3 any concerns)

3 holding the code pager will check out to NFS utilizing handoff cards@ 5:00-5:30 pm in the doctor's lounge

Task performed with cards updated, 3 +/- attending notified of significant changes updated

NFS does admissions and checks out to attending creating new handoff cards

NFS face to face checkout with both 3s and exchanges patient cards 6-6:30 a.m. in the doctor's lounge

NFS and NFJ meet at 5:30-6 a.m. to update NFS on overnight changes to any new admissions. NFS rounds on new admissions and NFJ leaves

NFS and NFJ discuss patient plan and NFJ takes calls on the new admission until the morning

3s divide the new admissions then round on the new patients and pages NFS if any specific questions arise prior to 8am

Admissions occurring during check out will be handled by the NFS until 7 am, then a face to face will occur again with a 3 with card exchanged

3 uses handoff cards for presentations on rounds. 3 then gives cards to assigned 1's who will utilize card then discard it into sensitive documents box to be shredded

3 and 1's on each team review pts and note any pts for any task/sick re-evals and make handoff card for them

C:\Users\jking11\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\IPXMGCWY\AA_Policy Procedure Manual 14-15.doc 89
3 and the 1 of his team who is working that weekend review pts and note any pts for any task/sick re-evals and make handoff card for them

1s of the other team discuss with 3 working that weekend their sick patients, and pending tasks to do, and give him the handoff cards for these pts

3 checks out to OCS after rounds, ~ 11:00 am- 2 pm, giving the handoff cards, and information about sick patients, tasks to do

OCS does admissions and checks out to attending creating new handoff cards

Task performed with cards updated, 3 +/- attending notified of significant changes

OCS face to face checkout with 3 working, exchanges patient cards 5:30-7:00 a.m. in the doctor's lounge

OC1 and OCS meet 8:30-9:00 pm to update OCS on overnight changes to any new admissions. OCS rounds on new admissions and OC1 leaves

OCS and OC1 discuss patient plan and OC1 takes calls on the new admission until 9 p.m.

3 rounds on the new patients and pages OCS if any specific questions arise prior to 8am

Admissions occurring after check out will be handled by the OCS until 8 am, then a face to face will occur again with 3 with card exchanged

3 uses handoff cards for presentations on rounds. 3 then gives cards to assigned 1’s(either team) who will utilize card then discard it into sensitive documents box to be shredded

Legend

3 - 3rd yr senior on days
1 - 1st yr intern on days
OCS - 3rd /2nd yr on call
OC1 - 1st yr on call

○ - Start and End of a process
△ - Task to perform
□ - Steps in the process
3rd yr senior on days
1st yr intern on days
1st yr on call

3's of both teams discuss sick patients/task and pending transfers before check out utilizing electronic notes (If a 3 is in clinic, the 1's of his team should discuss with the other 3 any concerns)

3 holding the code pager will check out to OC1 utilizing electronic notes @ 5pm

OC1 perform any task with notes updated

OC1 does admissions and checks out to home-call attending or senior creating new electronic notes

OC1 face to face checkout with both 3s, utilizing electronic notes 8:30-9:00 p.m.

When OC1 caps the nocturnist does the admission, notifies the floor attending in AM

3 assigned for new admissions each day meets with nocturnist around 6:30-7 a.m. for face to face check out of overnight admissions over the cap

3s divide the new admissions then round on the new patients and pages OC1 if any specific questions arise prior to 8am

3 uses utilizing electronic notes for presentations on rounds. 3 then gives notes to assigned 1's who will utilize note then discard it into sensitive documents box to be shredded

In addition to the above model, transfers from the 3rd floor & 2nd floor Telemetry Step Down Unit to the ICU should be done using the electronic handoff template.
VA Floor Team Handoff Flowchart

**Weekend**

Legend
- Start and End of a process
- Task to perform
- Steps in the process

3 3rd yr senior on days
1 1st yr intern on days
OC1 1st yr on call

3 and the 1 of his team who is working that weekend review pts and note any pts for any task/sick re-evals and make handoff electronic note for them

1s of the other team discuss with 3 working that weekend their sick patients, and pending tasks to do with electronic notes made for these pts

3 checks out to OC1 after rounds, ~ 11:00 am-noon, going over the electronic note, and information about sick patients, tasks to do

OC1 perform any task with notes updated

OC1 does admissions and checks out to home-call attending or senior creating new Electronic Notes

OC1 does face to face checkout with 3 with electronic handoff notes 8:30-9:00 p.m., then OC1 gives the code pager to the nocturnist at 9:00 p.m.

When OC1 caps the nocturnist does the admission, notifies the floor attending in AM

3 uses printed electronic notes for presentations on rounds. 3 then gives notes to assigned 1’s who will utilize then discard it into sensitive documents box to be shredded

3 rounds on the new patients and pages OC1 if any specific questions arise prior to 8:00 a.m.

3 working on weekend meets with nocturnist around 6:30-7:00 a.m. next day for face to face check out of overnight admissions over the cap OC1 on for next day picks up code pager from nocturnist.

C:\Users\jking11\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\IPXMGCWY\AA_Policy  Procedure Manual 14-15.doc
S and 1 review pts and note any pts for any task/sick re-evals and make electronic notes for them

S and 1 checkout to OC1 @ 5pm, including pts re-eval, tasks, and pending transfers going over the electronic note for each

OC1 does admissions and checks out to home-call attending or senior creating new electronic notes

OC1 perform any task with notes updated

S or 1 (during weekends when S is off) meets with nocturnist around 6:30-7:00 a.m. for a face to face check out of overnight admissions over the cap

When OC1 caps the nocturnist does the admission, notifies the ICU attending in AM

S rounds on new pts and pages OC1 if any specific questions arise prior to 8am (1 does the same on weekends when S is off)

S uses electronic notes to present on rounds and assigns the new admits to 1 who uses note and then appropriately discard it into sensitive documents box to be shredded

Legend:
- Start and End of a process
- Task to perform
- Steps in the process

Legend:
S 2nd yr senior on days
1 1st yr intern on days
OC1 1st yr on call