DEPARTMENT *of*
INTERNAL MEDICINE

James H. Quillen College of Medicine

EAST TENNESSEE STATE UNIVERSITY

2019-2020
Internal Medicine
Residency Handbook

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CONTACTS

Department Chair, Dr. Jeffery Summers	439-6282
Program Director Dr. James Myers	439-6389
Heather Grove, Program Administrator	439-6389
Carla Hill, Fellowship Coordinator	439-8048
Tammy Miller	439-6283
Becky Stallard	439-8705
Michelle Steele	439-6275
Jessi Arnold	439-6868
Office Fax	439-6386
HVMC Facility Coordinator – Rita Forrester	224-5075
JCMC Facility Coordinator – Tawana Holland	431-6431
VAMC – Birgit Goldfarb and Stephen Culbertson	926-1171, Ext. 2196
GME Office – Sissy Shipley (Insurance Issues)	439-8023
Security Offices:	
VAMC	926-1171, Ext. 7197
ETSU	439-4480
Clinics:	
JC MEAC	439-7280
Kingsport MEAC	246-7931
Medical Record Offices	
JCMC	431-5459
BRMC	844-3526
HVMC	224-6192
VAMC	979-7816

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Introduction

Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth. **(Int.A.)***

Internal medicine is a discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness. Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values. **(Int.B.)***

General: Residency training in Internal Medicine at ETSU is a 36-month program with exceptions given for prior credit based on evaluation by the American Board of Internal Medicine, ABIM. **(Int.C.)***

COMPACT BETWEEN RESIDENT PHYSICANS AND THEIR TEACHERS

Residency is an integral component of the formal education of physicians. In order to practice medicine independently, physicians must receive a medical degree and complete a supervised period of residency training in a specialty area. To meet their educational goals, resident physicians must participate actively in the care of patients and must assume progressively more responsibility for that care as they advance through their training. In supervising resident education, faculty must ensure that trainees acquire the knowledge and special skills of their respective disciplines while adhering to the highest standards of quality and safety in the delivery of patient care services. In addition, faculty are charged with nurturing those values and behaviors that strengthen the doctor-patient relationship and that sustain the profession of medicine as an ethical enterprise.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Core Tenets of Residency

Education Excellence in Medical Education

Institutional sponsors of residency programs and program faculty must be committed to maintaining high standards of educational quality. Resident physicians are first and foremost learners. Accordingly, a resident's educational needs should be the primary determinant of any assigned patient care services. Residents must, however, remain mindful of their oath as physicians and recognize that their responsibilities to their patients always take priority over purely educational considerations.

Highest Quality Patient Care and Safety

Preparing future physicians to meet patients' expectations for optimal care requires that they learn in clinical settings epitomizing the highest standards of medical practice. Indeed, the primary obligation of institutions and individuals providing resident education is the provision of high quality, safe patient care. By allowing resident physicians to participate in the care of their patients, faculty accepts an obligation to ensure high quality medical care in all learning environments.

Respect for Residents' Well-Being

Fundamental to the ethic of medicine is respect for every individual. In keeping with their status as trainees, resident physicians are especially vulnerable and their well-being must be accorded the highest priority. Given the uncommon stresses inherent in fulfilling the demands of their training program, residents must be allowed sufficient opportunities to meet personal and family obligations, to pursue recreational activities, and to obtain adequate rest. Schedules will meet ACGME Clinical Education and Experience guidelines. Additionally, efforts at recreational and social interactions are planned throughout the year at various times to promote teamwork and general well-being. Resident Assistance Program is available and detailed in section 8.1 of this handbook.

Commitments of Faculty

1. As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.

2. We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.

3. In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

4. We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.

5. We will do our utmost to ensure that resident physicians have opportunities to participate in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.

6. We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare residents to function effectively as members of healthcare teams.

7. In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.

8. We will evaluate each resident's performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.

9. We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.

10. We will nurture and support residents in their role as teachers of other residents and of medical students.

Commitments of Residents

1. We acknowledge our fundamental obligation as physicians—to place our patients' welfare uppermost; quality health care and patient safety will always be our prime objectives.

2. We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.

3. We embrace the professional values of honesty, compassion, integrity, and dependability.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

4. We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.

5. As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.

6. We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.

7. We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.

8. We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.

9. We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.

10. In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

This compact serves both as a pledge and as a reminder to resident physicians and their teachers that their conduct in fulfilling their obligations to one another is the medium through which the profession perpetuates its standards and inculcates its ethical values.

For more information about the Compact, go to www.aamc.org/residentcompact.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Program Requirements

Sponsoring Institution

(I.A.; I.B.)*

East Tennessee State University is the sponsoring institution and assumes ultimate responsibility. The program receives financial support for personnel management and education from four Participating Sites:

1. Mountain Home Veterans Affairs Medical Center (VAMC)
2. Johnson City Medical Center (JCMC)
3. Holston Valley Medical Center (HVMC)
4. Bristol Regional Medical Center (BRMC)

Resident Contingent

(III.B.1-2)*

The Program is in the process of establishing a set contingent of residents that include 12 categorical positions for each training level. Resident complement is provided annually by the Designated Institutional Officer (DIO).

Program Leadership

(I.A.2.b-c)*

There is a Program Director (PD) **(II.A)*** that receives salary support for administrative time based on the VA campus in the Department of Internal Medicine. There are also three Associate Program Director (APD) **(II.A.2.b)*** positions who receive salary support and appropriate administrative time. The PD and all APDs are members of the Association of Program Directors in Internal Medicine (APDIM) and participate in skills conferences each year. Any changes in program leadership must be reported to ACGME via the ADS. **(II.A.4.a).(16)***

Current Program Leaders:

Jonathan Moorman, MD: Vice-Chair of Education, Research and Scholarship
James Myers, MD: Program Director
Diana Nunley-Gorman, MD: APD Ambulatory Care – HVMC Site Director
Debalina Das, MD: APD Simulation/Quality/Safety – JCMC Site Director
Medhi Pourmorteza, DO: VAMC APD
Girendra Hoskere, MD: BRMC Site Director

Subspecialty Education Coordinators:

Subspecialty Coordinator	Subspecialty	Site
Vijay Ramu, MD	Cardiology	JCMC
Girendra Hoskere, MD	Pulmonary	BRMC
Girendra Hoskere, MD	Critical Care	BRMC
James Luna, MD	Emergency Medicine	HVMC

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Vini Krishnan, MD	Geriatrics	VAMC
T. J. O'Neill, MD	Nephrology	VAMC
Jeremiah Marsh MD	Neurology	CLINIC
Kanishka Chakraborty, MD	Hematology-Oncology	ETSU
Mark Young, MD	Gastroenterology	ETSU
Paras Patel, MD	Infectious Disease	ETSU
Saba Aziz, MD	Endocrinology	ETSU
Suzanne Moore, MD	Rheumatology	CLINIC

Core Faculty
(II.B.4.)*

Core Faculty members are approved by the PD **(II.B.4.a)*** and provide support and education to the residents and program administrative staff. **(II.B.4.)***

Current Core Faculty along with current Program Leaders listed above:
Jack Goldstein, MD: JCMC Faculty Member

Program Coordinator
(II.C.)*

There is a Program Coordinator who receives salary support, reports to the PD and is available to the residents and faculty for the effective administration of the Program.

General Scheduling
(IV.C.1.)*

A minimum of 1/3 of training occurs in both inpatient and ambulatory settings not including ER time. **(IV.C.3.)*** In general, residents spend approximately 6 months at VAMC and 3 months each at the community sites. A block scheduling system ensures no competing obligations between IP/Ambulatory demands.

At the community sites: Interns rotate to cover night shift for approximately 2 weeks at HVMC while senior residents do a night float at both JCMC and HVMC but not at the VAMC. Floater call at HVMC is minimized and is primarily done by residents on the ER rotation.

At the VAMC: Call is approximately every day rotating between two teams. Each team consists of one senior and two interns. Teams are available between 7 am – 7pm, and work 6 days out of 7 per week. There is a Night Medicine **attending** physician system to cover both ICU and Ward teams.

PGY-1 residents are never scheduled on In-Patient rotations without a PGY-2 or 3 resident or attending to directly supervise them. **(IV.C.3.g).(8)***

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Transplant Rotations
(IV.C.3.g).(10)*

There are no Transplant Rotations in this Internal Medicine program.

Program Letters of Agreement
(I.B.2)*

ETSU Department of Internal Medicine has a Program Letter of Agreement (PLA) between the program and each participating site providing a required assignment. This letter is renewed at least every 10 years, uses the format provided by the Department of Graduate Medical Education and must be approved by the DIO. **(I.B.2.a)***

The PLA:

1. Identifies faculty who assume educational and supervisory responsibilities for residents
2. Specifies their responsibilities for teaching, supervision and formal evaluation
3. Specifies duration of the rotation as well as goals and objectives
4. States policies and procedures to govern the education

Additions or deletions of sites are reported in the ACGME ADS system.

Site Specific Resources

- Adequate teaching space is available as a team or conference room at each site. **(I.D.1.f)***
- Adequate computer access is constantly evaluated and additions requested as needed for each site. **(I.D.1.f)***
- On-Call facilities that provide privacy, safety and a space to secure belongings is present at each site. Inspections by program staff are performed at least semi-annually and results provided to site coordinators. **(I.D.2.b)***
- Food is provided at each site for those residents on-call. Site specific information is provided at orientation. **(I.D.2.a)***
- Clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care are provided. **(I.D.2.c)***

Medical Information Access
(I.D.3)*

Residents have ready access to specialty and other reference material in print at the various hospital libraries and online via the ETSU Medical Library as well as the site specific database. Online resources are available at all time for search capabilities.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Resident Recruitment / Appointments

RESIDENT ELIGIBILITY

(III.A.1)*

Resident applicants must meet the following qualifications for appointment to the Quillen College of Medicine residency programs:

1. Graduates of medical schools in the U.S. and Canada accredited by the Liaison Committee on Medical Education (LCME), or

2. Graduates of medical schools in the U.S. and Canada accredited by the American Osteopathic Association (AOA), or

3. Graduates of medical schools outside the United States and Canada who have received a currently valid certificate from the Educational Commission for Foreign Medical graduates prior to appointment.

4. Residents transferring from another program must provide written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from previous programs. **(III.C.*)**

5. Preliminary residents may not be appointed to additional preliminary years if satisfactorily completed. **(III.C.1)***

RESIDENT SELECTION

Residents are selected on a fair and equal basis without regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status. Performance in medical school, personal and official letters of recommendation, achievements, and humanistic qualities will be used in the selection process. The Sponsoring Institution must ensure that ACGME accredited programs select from among eligible applicants on the basis of residency program-related criteria such as their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.

All programs will participate in the NRMP and will select residents according to NRMP policies and procedures. Each program will develop specialty specific criteria according to its own program's needs and those of the institution. These criteria may encompass personal, professional and educational characteristics of the candidate. The enrollment of non-eligible residents may be a cause for withdrawal of accreditation of the involved program.

Residents with prior residency training experience not entering through the NRMP match will have their history evaluated by the ABIM. Written or electronic training evaluations and competencies will be obtained prior to offer. Credit given will be based on their evaluation. A summative evaluation must be obtained prior to contract. The same will be offered for those residents transferring to another program from this residency in a timely manner.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

RESIDENT BACKGROUND CHECK POLICY

1. Review and approval of a completed Criminal Background Check (CBC) is a precondition to employment for new resident and fellow physicians. Based on requirements mandated by the State of Tennessee (T.C.A. § 63-1-149), Quillen College of Medicine will not employ any resident or fellow who appears on any state's sexual offender registry, the national sex offender public registry website coordinated by the United States Department of Justice, any state adult abuse registry, or the Tennessee Department of Health's elder abuse registry. The CBC may also reveal information not contained in the above registries that could disqualify one from being considered for employment. In addition, all residents will undergo background checks through the VA hospital system.

2. If the VA reports a positive background check, the involved resident may be immediately removed from all clinical activities and placed on leave with pay for 30 days. The resident's department will be responsible for all salary and benefits incurred while the resident is on leave.

3. If review of the resident's administrative documents reveals dishonesty (or failure to disclose) related to the positive background check, the resident will be terminated.

4. Within 48 hours of notification of the background problem, the Executive Associate Dean for Graduate Medical Education will appoint one Program Director and one Chairman (neither of whom will come from the resident's department) to a subcommittee chaired by the Executive Associate Dean for Graduate Medical Education. This subcommittee will review all appropriate information and may interview the resident involved and other appropriate personnel. Within fourteen (14) days, they will forward recommendations for a course of action to the Executive Associate Dean for Graduate Medical Education. The Executive Associate Dean for Graduate Medical Education will forward the subcommittee's recommendation to the Dean, with comments regarding the recommendation.

5. The Dean will meet with the Chair of the involved department to discuss the subcommittee's recommendations. The Dean may meet with the involved resident.

6. The Dean will deliver his decision regarding the resident within 30 days from the notification by the VA of the concern.

7. The resident shall have the right of due process, through the Vice President for Health Affairs, regarding this decision.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

New Innovations™

All the residency programs at East Tennessee State University use a web-based, residency management system called New Innovations (www.new-innov.com). Internal Medicine uses this system for posting call schedules, logging procedures, and Clinical Education and Experience as well as the evaluation process. When you begin the program, you will be given a log-on and password, both of which you can change once you log on. Failure to complete your assigned tasks in a timely manner could result in disciplinary action.

SOCIAL NETWORKING GUIDELINES

The Graduate Medical Education Committee recommends that residents and fellows exercise caution in using social networking sites such as but not limited to Facebook or Twitter. Items that represent unprofessional behavior posted by residents on such networking sites are not in the best interest of the University and may result in disciplinary action up to and including termination. Residents and fellows are expected to exhibit a high degree of professionalism and personal integrity consistent with the pursuit of excellence in the conduct of his or her responsibilities. They must avoid identifying their connection to the University if their online activities are inconsistent with the values or could negatively impact the University's reputation.

If using social networking sites, residents and fellows should use a personal e-mail address as their primary means of identification. Their University e-mail address should never be used for personal views. Residents who use these websites must be aware of the critical importance of privatizing their websites so that only trustworthy friends have access to the websites/applications.

In posting information on personal social networking sites, residents may not present themselves as an official representative or spokesperson for a residency/fellowship program, hospital, Department of Veterans Affairs or the University. Patient privacy must be maintained and confidential or proprietary information about the University or hospitals must not be shared online. Patient information is protected under the Health Insurance Portability and Accountability Act (HIPAA). Residents have an ethical and legal obligation to safeguard protected health information and posting or e-mailing patient photographs is a violation of the HIPAA statute.

See the link for 10 simple rules for doctors and social media.
http://www.kevinmd.com/blog/2013/05/10-simple-rules-doctors-social-media.html

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

INTERNAL MEDICINE RESIDENCY AND FELLOWSHIP DRESS CODE

PURPOSE:
This policy is written to guide RESIDENTS AND FELLOWS of the Internal Medicine Residency and Fellowship Programs in presenting a professional image by outlining reasonable and appropriate appearance in the workplace. Appropriate dress and personal grooming are components of a safe and professional environment. Every resident and fellow represents the standards and professional image set forth by the department and by the medical profession.

It is the responsibility of all residents and fellows to dress appropriately for the workplace and to foster confidence and trust in patients, families, visitors, and staff through professional behavior and appearance.

GUIDELINES:

1. All residents and fellows shall wear their white lab coats at the discretion of attending/precepting physician. Badges must be worn at all times and displayed in a location that is easily visible to patients, visitors, and staff, when on duty or on medical center premises.
2. General attire must be clean and neat at all times.
3. Appropriate attire is considered to be dress shirts (preferably ties), dresses, pantsuits, blouses, skirts, sport coats, dress slacks, and shirts with collars.
4. Jeans, tennis shoes, shorts, skirts three inches of more above the knee, tube tops, low cut tank tops, t-shirts, midriff tops, sundresses without a jacket or blazer, see-through and low cut blouses, sweatpants, sweatshirts, and leather attire are considered unreasonable and inappropriate attire for the work place.
5. When direct patient care responsibilities necessitate physical contact do not wear large bulky jewelry or jewelry that may inadvertently cause injury to patients.
6. Hair should be neatly arranged in such a manner that it does not fall on patients or be grabbed by a patient. Facial hair should be neatly groomed to present a professional image.
7. Perfume, cologne, or other fragrance products should be moderately used to avoid being offensive or causing discomfort to others.
8. Personal Hygiene will be expected of all residents in all settings.
9. Undergarments should not be visible through outer clothing.
10. Shoes must be closed-toed in the patient care areas (no flip-flops or sandals). Shoes should be of reasonable height and comfortable enough for the resident or fellow to be able to respond to any type of emergency in a healthcare setting.
11. Visible body piercing must be conservative and jewelry must be small in size.
12. CDC requires that fingernails be kept clean and short for patient care and for the proper fit of gloves or other protective equipment. Artificial Nails are not permitted.
13. Scrubs need to be covered when leaving patient care areas.
14. Scrubs may be worn on nightshift and call days, but should <u>never be worn to continuity clinic setting</u>. Clean white coats are expected to be worn in clinic at all times.

COMPLIANCE: All residents and fellows are expected to comply with this policy. Any reporting to duty dressed in a manner inconsistent with this policy will be counseled appropriately and may be asked to correct attire.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

RESIDENT'S AND FELLOW'S WELL BEING
(VI.C)*

East Tennessee State University, Quillen College of Medicine's Resident Assistance Program (RAP) is a confidential counseling and referral service for East Tennessee State University Medical School residents and their families. The purpose of the program is to encourage self-referral so that you can be helped with training issues, personal and marital concerns before they lead to more serious difficulties. The first six visits are free and subsequent visits are covered by resident health insurance with the normal deductible and co-pay applied.

As resident physicians, you should strive to manage professional and personal stress, to maintain your own health and well-being so that you can maximize your ability to provide quality health care to your patients. The program provides a link to self-screening tools on the website.

Stress is part of everyone's life. It can become overwhelming when not managed properly can lead to physical, mental and spiritual difficulties.

The RAP is here to provide you with help in managing stress in both your personal and professional lives through confidential counseling, education, and in some cases medication. This includes assistance with marital counseling and other relationships.

Below are listed some causes of excessive stress:

-Excessive anxiety

-Overwhelming responsibility

-Perfectionism

-Lack of sleep/Long work hours

-Marriage and family conflict

-Physical illness

-Social isolation

-Unresolved bereavement issues

-Culture adaptation issues

-Sexual/Gender orientation confusion

-Sexual harassment

-Perceived lack of staff or attending support

-Depression or other mental health stressors

Contact: Phillip Steffey, M.Div., L.C.S.W.
(423) 854-0342

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

ACADEMIC CONFERENCE ATTENDANCE

(IV.C.4.a)*

Policy:

Since residents are in an advanced training program, academic conferences are very important and an essential part of your training. Therefore, the QCOM IM Residency Program requires **100%** attendance and participation of conferences and educational curriculums sponsored by department:

1. Academic Half Day –
   - Department of Medicine Education Conference
   - Longitudinal Board Review
   - Core Conferences
   - Journal Club
   - Quality Safety/High Value Care

Procedure:

1. Residents are responsible for electronically documenting arrival and departure from conferences.
2. The IM residency office will track attendance using the New Innovations™ Conference Module.
3. To accommodate leave, call and post call, the AHD will be recorded and should be viewed at the first opportune time following the original presentation. It will be the responsibility of the resident to notify the Residency Office to ensure credit for any conference viewed online.
4. It is expected that residents will arrive on time and that beepers will be passed to the attending physician or the fellows on the service.
5. Cell phones should be set to vibrate.
6. No Laptop usage during attending presentations unless instructed otherwise.
7. No sitting on the back two rows during AHD.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

WORKER'S COMPENSATION INFORMATION FOR ETSU RESIDENTS AND FELLOWS

As soon as possible after an accident occurs (including needle sticks), you should inform your supervisor or attending at the site who will facilitate site-based reporting, then call the worker's compensation call center at ***866-245-8588*** (toll- free) and complete an accident form via telephone. Information obtained by the call center enables the claims adjuster to determine whether your injury is compensable under the worker's compensation law. Your supervisor will be contacted to verify the incident. A claim number will be given if it is determined the injury is compensable under worker's compensation. The claim number should then be given to the health care provider or the pharmacy for payment by worker's compensation. The forms required for a worker's compensation injury from the Human Resources website should be completed with the claim number noted and forwarded to Human Resources on the next business day.

CONTACT INFORMATION:

Jodi Epps – Human Resources during business hours – (423) 439-4787
Debra Shaw – GME office after hours and weekends – (423) 302-9280

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

IM Resident Clinical Education and Experience Policy
(VI.F.)*

Purpose:

To develop a process for ensuring compliance with ACGME Clinical Education and Experience (CEE) Requirements as described in the Common Program Requirements.

Policy:

Resident Clinical Education and Experience (CEE) in the Learning and Working Environment are vital in educating our residents and faculty as they relate Professionalism, Personal Responsibility and Patient safety. The learning objectives of each of the Quillen College of Medicine Residency Programs must be accomplished by an appropriate blend of supervised patient care responsibilities, clinical teaching and didactic educational events while assuring against any compromise by excessive reliance of residents to fulfill non-physician service obligations. A culture of professionalism supporting patient safety and personal responsibility is instituted by each QCOM Residency Program Director and must ensure each Resident/ Fellow and Faculty member demonstrate an understanding and acceptance of their personal role in:

- Patient safety and welfare
  - Patient Safety Committee Membership
  - Patient Safety Conferences
- Patient and family centered care
  - Patient Centered Medical Home certification/education at clinic
- Fitness for duty
  - "Boot Camp" for Interns
- Time management before, during and after clinical assignment
  - Time Management lecture
  - AMA Competency Education Program
- Recognition of impairment, including illness and fatigue in themselves and their peers as well as site specific fatigue mitigation plans **(VI.D.)***
  - Site specific fatigue mitigation plans
  - Resident mental health lectures
  - Preceptor/Attending feedback
- Healthcare Quality Indicators
  - AHD education
  - Site specific lectures
- Honest and accurate reporting of CEE hours, patient outcomes and clinical experience data
  - Education at orientation with periodic reminders at AHD

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Definitions:

Attending Physician: Any appropriately credentialed and privileged member of the medical staff who accepts full responsibility for a specific patient's medical/surgical care.

Clinical Education and Experience : CEE is defined as all clinical and academic activities related to the program; i.e., patient care (in and out patient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in house during call activities, and scheduled activities, such as conferences. CEE DOES NOT include reading and preparation time spent away from the duty site.

External Moonlighting: Voluntary, compensated, medically-related work performed outside the institution where the resident/fellow is in training or at any of its related participating sites.

Faculty: Any individual who has received a formal assignment to teach resident/fellow physicians.

Fatigue Management: Recognition by either resident/fellow or supervisor of a level of resident /fellow fatigue that may adversely affect patient safety and enactment of solution to mitigate the fatigue.

Fitness for Duty: Mentally and physically able to effectively perform required duties and promote patient safety.

Scope: All Internal Medicine Residents

Procedure:

1. CEE must be limited ***to 80 hours per week, averaged over a four-week*** period. **(VI.F.1)***

2. Time spent by residents in Internal and External Moonlighting must be counted towards the 80-hour Maximum Weekly Hour Limit. **(VI.F.1)***

3. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (***when averaged over four weeks***.) At home call cannot be assigned on these free days. **(VI.F.2d)*** No at home call is assigned unless PGY4 Chief for back-up call.
4. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. **(VI.F.3.a)***
5. Residents are allowed to use up to four hours of additional time for activities related to patient safety such as providing effective transitions of care, and/or resident education. (**VI.F.3.a).(1)***

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

6. Residents must not be assigned additional patient care responsibilities during these four hours. **(VI.F.3.a).(1).(a)***

7. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. **(VI.F.6*)**

8. Residents/Fellows must not be scheduled for in-house call more frequently than every third night (when averaged over a four-week period.) **(VI.F.7)***

9. Time spent on patient care activities by residents on at-home call must count toward the 80-hour work week. **(VI.F.8.a)***

10. Residents/Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of in-patient care must be included in the 80-hour weekly limit **(VI.F.8.b)***

11. PGY-II and III residents may moonlight with the approval of the CCC committee. All moonlight hours must be included in the 80-hour weekly maximum. PGY I residents are not allowed to moonlight. **(VI.F.5)***

12. Senior Residents will be held accountable for all Clinical Education and Experience violations reported by interns on New Innovations.

13. Faculty will be held accountable for all Clinical Education and Experience violations reported by senior residents on New Innovations.

14. Documented falsification of Clinical Education and Experience reporting or counseling others to falsify Clinical Education and Experience reports will ***result in immediate probation.***

15. Faculty are at risk of losing the privilege of having residents assigned to them if, after investigation, they are found to be the cause of the Clinical Education and Experience violations of their assigned residents.

16. Clinical Education and Experience are monitored by the IM Program Director and Residency Coordinator. Outliers are discussed at the level of the PEC and by the Quillen College of Medicine GME Office. Corrective actions are developed, tracked and trended for all confirmed work hour violations.

17. There is no “at home” call in the Internal Medicine residency program at ETSU. **(VI.F.7)***

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

EAST TENNESSEE STATE UNIVERISTY
INTERNAL MEDICINE RESIDENCY PROGRAM

MOONLIGHTING POLICY
(VI.F.5)*

Review the attached Institutional "Moonlighting Policies" of East Tennessee State University Quillen College of Medicine.

Moonlighting is not recommended. However, the Internal Medicine Residency program at East Tennessee State University DOES OCCASIONALLY ALLOW moonlighting for second and third year residents **ONLY when not on a ward rotation** and when the resident is **not on back-up call**. **PGY-1 residents are NOT allowed to participate in moonlighting**. **(VI.F.5.c)*** The ACGME requires that the Residency Program Director monitor all moonlighting activities – internal and external. Because of this requirement and to ensure that moonlighting does not interfere with the resident's training and education, moonlighting requests must be submitted to the Clinical Competency Committee IN WRITING on the "Request for Moonlighting" form for approval. After approval, the resident must provide the Program Director with a moonlighting schedule each month prior to date of scheduled moonlighting activity. It should be submitted to the Residency Program Coordinator by the first of each month for the Program Director's review.

The resident must log ALL internal and external moonlighting hours into New Innovations. Both internal and external moonlighting will be counted against maximum work hours and monitored for any Clinical Education and Experience violations. **(VI.F.5.b)*** Failure to document moonlighting hours or moonlight without permission from the program as well as any other non-compliance with the Internal Medicine Residency Program's Moonlighting Policy will result in disciplinary actions up to and including dismissal from the training program.

The Department of Internal Medicine requirements for Moonlighting:
- Resident must have a minimum ITE and spring mock exam score of 50th %ile, and
- Will not moonlight while on wards or clinic block, and
- Will be subject to medical knowledge testing once a quarter while moonlighting, and
- Understands and agrees to adhering to ACGME Educational and Clinical Hours.

Contact the Residency Program Administrator for specific forms and approval for moonlighting.

2/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Overall Goals and Objectives of IM Resident Training
(IV.A.1)*

I. Knowledge

Goal:

The Internal Medicine resident will be a scholar who has a breadth and depth of knowledge that facilitates the practice of internal medicine. Residents will gain competencies in the areas of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills and professionalism and systems based practice.

Objectives:

2. The resident will be familiar with fundamental aspects of all disease processes listed in the written curriculum. In most cases, this will include pathophysiology, epidemiology, diagnosis, and treatment of disease.

3. The resident will be expected to attend 100%, when not on scheduled leave or one of the exceptions to attendance, of Academic Half Days over the three-year training period. Attendance will be taken and monitored on New Innovations and only excused for approved leave. Each lecture will be placed on D2L and made available to any resident unable to attend a specific lecture.

4. Each resident will demonstrate at least one scholarly activity per residency. This may include knowledge developed from a research project, case study or literature review. It may also include a special lecture or performance improvement project presentation. Residents are encouraged to present at both regional and national levels.

5. Every resident will participate in a Safety and Quality Improvement project during their training, at either their assigned ambulatory clinic or hospital.

6. The program will have the following composite objectives with respect to resident knowledge base:
   a. Maintain composite In-Training scores in the top 65 percentile over the next three years. All PGY Levels are required to take the In-Training examination. Third year residents should have ≥70% correct questions.
   b. The program strives to have a 100% ABIM Board pass rate for all graduates.

7. The residents will be given an opportunity to care for the patient both in the inpatient and ambulatory environment utilizing nursing, case management, pharmacists and dietitians. Didactics will be provided by these subject matter experts as well.

8. Appropriate use of consultants is also a goal of education and is provided in a timely manner based on hospital specific policies at each site. Senior residents are charges with interactions

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

with consultants per these same policies. **(II.D.7)***

9. Residents will be required to participate ***in one volunteer activity per training year***. Applicable items include: indigent clinic volunteer, patient educator or other activity preapproved by PD. Hours should be logged and activity entered in New Innovations.

II. History and Physical Exam Skills Goal:

Train residents to possess excellent clinical skills--including an appreciation of and skill in obtaining clues to diagnosis through patient interview. The resident should be trained to perform a thorough physical examination with proper technique and with an ability to do a focused exam depending on particular presentation.

Objectives:

1. Each resident will perform a complete history and physical examination while being evaluated by a full-time faculty member during the first two months of training and intermittently during subsequent two years of training.

2. Attending physicians will evaluate the history, physical exam skills, clinical judgment, and professionalism of residents using an objective assessment form.

3. Teaching rounds will be formally scheduled at least five times per week and will include instruction by the attending on bedside diagnosis.

4. Special lectures on physical diagnosis will be included in core lectures. Some of these lectures will include a literature review of the sensitivity and specificity of physical exam techniques.

5. Upper level residents with excellent clinical skills will be chosen to assist with the medical student Academic Half Day.

III. Diagnostic Tests and Therapeutic Interventions Goal:

The resident will be a wise and knowledgeable physician who recognizes the value and limitations of diagnostic tests and the indications and complications of all therapeutic options. The resident will be skilled in making therapeutic decisions both in the inpatient and outpatient setting. The resident will appreciate the role of the medical literature in reaching therapeutic decisions and the diseases and interventions for which consultation is appropriate.

Objectives:

1. The resident will use assigned readings and core lectures to supplement clinical experience in diagnostic and therapeutic decision making.

2. The resident's developing abilities in diagnostic and therapeutic decision making will be

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

evaluated daily by attending physicians. CQI conferences, chart audits, clinical scenarios tested by written exam will supplement this learning experience.

3. The diagnostic and therapeutic skills necessary to develop in each specialty will be reviewed by each resident using the written curriculum that follows.

4. Core lectures will include specific knowledge about clinical decision making, technique and complications of procedures, literature review, and computer-assisted diagnosis. Residents will be expected to demonstrate a graduated level of knowledge over the course of their residency.

5. Specific attention will be given to provide indications, process, components of informed consent and proper utilization of specialized procedures and testing to include:
   - Cardiac Testing/Imaging
   - Bronchoscopy
   - Endoscopy
   - PET Scan
   - Hemodialysis
   - Specialty imaging
     - CT
     - MRI
     - Ultra Sound
     - Fluoroscopy
     - Angiography

IV. Prevention Based

Goal:

The prevention of disease and disability will become an integral part of Internal Medicine's teaching. In addition to preventive medicine as a centerpiece of Primary Care, each subspecialty will emphasize the special aspects of prevention in their specialty.

Objectives:

1. The resident will be knowledgeable about all aspects of prevention as listed in the written curriculum.
2. Preventive medicine will be part of ambulatory care and continuity clinic teachings.

3. Preventive medicine will be especially emphasized in core lectures.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

V. Special Values and Attitudes

Goal:

Residents will:

- Demonstrate professionalism and professional integrity
- Value the physician-patient relationship
- Demonstrate high standards of moral behavior
- Accept fundamental responsibility for caring for others
- Demonstrate compassion and empathy
- Work cooperatively and respectfully with other members of the health care team
- Integrate care to community health care resources

Objectives:

1. Faculty will serve as role models in the values and attitudes that they possess.

2. Residents will develop skills in evaluating peers on these attitudes. Residents will not accept unprofessional behavior in their peer group and will know how to deal with the issue of physician impairment.

3. Residents will use principles learned in medical ethics as standards of professional behavior.

4. Residents will seek advice from program director, faculty advisor, and ethics committee when issues of professional behavior need clarification. Core lectures on professionalism, ethics, legal aspects of medicine, and patient-physician relations will supplement ward and outpatient experiences. The ABIM guidelines on professionalism and humanistic practice of medicine are included in the written curriculum.

VI. Resources

1. Training is provided in both inpatient and outpatient settings at four clinical sites. **(II.D.1)***

2. Subspecialty exposure will be provided in both clinical and didactic format. Subspecialty training is duplicated at the VA and community sites as possible and is inpatient to provide exposure to a broad age range including geriatrics and well as both sexes.

3. Goals and objectives for each rotation are found on the New Innovations site and are evaluated annually by the Program Evaluation Committee (PEC) and rotation supervisors. **(IV.A.2)***

4. Evaluations include rotation supervisor assessment of resident competency in prescribed goals and objectives.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Principal Educational Goals by Relevant Competency

In the lists below, the principal educational goals for the Inpatient Floor rotations are indicated for each of the six ACGME competencies.

1) Patient Care - Principal Educational Goals

Learning Activities:

- Interview patients skillfully
- Examine patients skillfully
- Define and prioritize patients' medical problems
- Generate and prioritize differential diagnoses
- Develop rational, evidence-based management strategies

2) Medical Knowledge - Principal Educational Goals

Learning Activities:

- Expand clinically applicable knowledge base of the basic and clinical sciences underlying the care of medical inpatients
- Access and critically evaluate current medical information and scientific evidence relevant to patient care

3) Practice-Based Learning and Improvement - Principal Educational Goals

Learning Activities:

- Identify and acknowledge gaps in personal knowledge and skills in the care of hospitalized patients
- Develop and implement strategies for filling gaps in knowledge and skills

4) Professionalism - Principal Educational Goals

Residents are expected to demonstrate:

- Compassion, integrity, and respect for others **(IV.B.1.(1).(a)***
- Responsiveness to patient needs that supersedes self-interest **(IV.B.1.a(1).(b)***
- Respect for patient privacy and autonomy **(IV.B.1.a).(1).(c)***
- Accountability to patients, society and the profession **(IV.B.1.a).(1).(d)***
- Respect and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities and sexual orientation **(IV.B.1.a).(1).(e)***
- Ability to recognize and develop a plan for one's own personal and professional well-being **(IV.B.1.a).(1).(f)**
- Appropriately disclosing and addressing conflict or duality of interest **(IV.B.1.a).(1).(g)**

5) Interpersonal Skills and Communication - Principal Educational Goals

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Learning Activities:

- Communicate effectively with patients and families
- Communicate effectively with physician colleagues at all levels
- Communicate effectively with all non-physician members of the health care team to assure comprehensive and timely care of hospitalized patients
- Present patient information concisely and clearly, verbally and in writing
- Teach colleagues including medical students effectively

6) Systems-Based Practice - Principal Educational Goals

Learning Activities:

- Understand and utilize the multidisciplinary resources necessary to care optimally for hospitalized patients
- Collaborate with other members of the health care team to assure comprehensive patient care
- Use evidence-based, cost-conscious strategies in the care of hospitalized patients

Evaluation Methods:

- During inpatient rotations, residents are formally evaluated in writing or online within their performance by the six core competencies, using ACGME Internal Medicine milestones as framework. Elevators will include: attending physician, resident peers on the team, as well as medical students, nurses and physician patients, thereby obtaining a true 360 º evaluation of the resident. All of these evaluations are reviewed by the program office and reviewed with the resident by the Program Director at the time of their semi-annual feedback meetings. The Program Director reviews all evaluations. If an unfavorable or marginal evaluation is received on any resident, an urgent appointment with the Program Director is scheduled with that resident to review the issues raised in the evaluation.

- The Program Director meets regularly with the Clinical Competency Committee (CCC) to review resident performance in an ongoing fashion. Information from these meetings is incorporated into the feedback residents receive at their regular meetings with the Program Director. Additionally, the CCC provides the Milestone review and is responsible for documenting all ACGME requirements in WebADS biannually for every resident.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

RESPONSIBILITIES OF THE CLINICAL COMPETENCY COMMITTEE

The Clinical Competency Committee (CCC) has primary responsibility for monitoring the competence and professionalism of the internal medicine residency for the purposes of recommending promotion and certification, and for initial counseling, probation or other remedial or adverse action.

Membership:
The CCC is appointed by the program director. Members of the Committee are chosen by the Committee Chair, may include the Key Clinical Faculty and must include at least one core faculty member. In addition, the Program Director, and one Chief Medical Resident (when the position is filled) serve as members. The CCC must have at least 3 members. **(V.A.3.a)***

Responsibilities: (V.A.3.b)*
The CCC will meet each fall and spring per academic year to review each resident's portfolio and generate Milestones to report to the ACGME. Additionally general meetings will be scheduled every other month and ad hoc meetings may be required to address pressing resident issues. The Chair or his/her designee will keep detailed minutes of all meetings. The QCOM IM CCC Policy Members may also be asked to participate in semi-annual resident performance reviews in conjunction with the Program Director and Associate Program Directors.

Committee members will participate:

- In reviewing all resident evaluations **(V.A.3.b).(1)***
- Determine each resident's progress on achievement of the specialty-specific Milestones semi-annually **(V.A.3.b).(2)***
- Meet prior to the resident's semi-annual evaluations and advise the program director regarding each resident's progress **(V.A.3.b).(3)***

A resident may be brought up for discussion by the CCC for any of the following reasons:

- Recommendation by the Program Director
- Consistently low or unsatisfactory evaluation scores
- Consistent lack of adherence to program requirements, including professionalism issues
- A ***specific incident that requires review*** by the CCC for possible probation or dismissal

The committee may make the following recommendations and the recommendations must follow the IM Program policies and/or the QCOM GME policies:

- No further action necessary
- Letter of concerns with specific terms and remediation recommendations
- Probation with specific terms and/or referral to the remediation subcommittee for specific recommendations
- May be with or without extension of time at level of training
- Delay or denial of promotion or board recommendation
- Termination

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Current Clinical Competency Committee Members for Academic Year 2019-2020

Dr. Diana Nunley, APD, Committee Chairperson
Dr. Bhavsar Gajjar
Dr. Jonathan Moorman, Vice Chair
Dr. Jim Myers, Program Director
Dr. Matt Parks
Dr. Blair Reece
Dr. Jeffery Summers, Department Chairperson
Dr. Jennifer Treece

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

THE INTERNAL MEDICINE MILESTONE PROJECT

A Joint Initiative of
The Accreditation Council for Graduate Medical Education
and
The American Board of Internal Medicine

MILESTONES

It is anticipated that residents will reach certain milestones in their training as remonstrated by the following General Competency Goals and Objectives for level of training.
General Competencies Goals and Objectives for Level of Training within the milestone framework are:

PATIENT CARE

PGY 1	PGY 2	PGY 3
• Monitors and Follows Up Patients • Information Gathered Is Accurate • Daily Notes Are Focused and Pertinent • Begins to Perform ABIM Invasive Procedures • Discharge Summaries are Accurate and Finished in a Timely Fashion • Performs a Thorough History and Physical Examination • Formulates a Reasonable Diagnostic and Therapeutic Plan • Can Competently Use a Computerized Medical Record	• Can Supervise Patient Care Activities of Students and PGY 1 Residents • Interprets Diagnostic Studies Accurately • Can Manage Multiple Problems Simultaneously • Considers Patient Preferences When Making Health Care Decisions • Has Performed the Majority of ABIM Invasive Procedures	• Shows Independence to Act as an Internal Medicine Consultant • Formulates Appropriate Plans in Ambiguous Clinical Situations

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

MEDICAL KNOWLEDGE

PGY 1	PGY 2	PGY 3
• Attends Required Conferences • Has Clinical and Relevant Basic Science Knowledge of Assigned Patient's Problems • Can Use Online Medical Data Base • Independently Reads and Accumulates Knowledge of Internal Medicine	• Attends Weekly Internal Medicine Review Sessions • Takes the Monthly Internal Medicine Review Test • Presents at Journal Club and Morning Report • Is Aware of Common Drug/Drug Interactions • Knows Precautions and Contraindications of Medications Used • Recognizes Basic ECG Abnormalities Including Common Arrhythmias • Teaches Students and PGY 1 Residents	• Has Started a Project to Demonstrate Scholarly Activity • The Resident Will Likely Pass the ABIM Examination

PATIENT-BASED LEARNING IMPROVEMENT

PGY 1	PGY 2	PGY 3
• Evaluates Basic Patient Preventative Medicine and Performance Measures • Recognizes Limitations & Asks for Advice When Appropriate • Requests Appropriate Consultation	• Develops Self-Evaluation of Clinical Performance	• Develops a Portfolio of Clinical Performance Measures

INTERPERSONAL AND COMMUNICATION SKILLS

PGY 1	PGY 2	
• Fluently Speaks and Understands the English Language • Understands Patient's Level of Communication • Effectively Communicates and Updates Patients About Their Condition • Develops Listening Skills	• Able to Discuss End of Life Care with Patients and Families • Counsels and Educates Patients and Families • Can Interact with Consultants • Explains Complex Diagnoses To Patients and Families	

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

PROFESSIONALISM

PGY 1	PGY 2	PGY 3
• Establishes Trust and Demonstrates Honesty with Patients and Staff • Information Given to Colleagues and Supervisors Is Accurate and Reliable • Respects the Opinions of Others • Respects Differences of Culture, Gender, Race and Age • Accepts Responsibility • Appearance Is Neat, Clean and Professional • Is Free From Substance Abuse or Is Undergoing Rehabilitation	• Displays Leadership • Appropriately Delegates Work Assignments and Authority • Acknowledges Errors and Misjudgment and Works to Minimize Them	• Has Clinical Knowledge and Leadership Skills to Be a Chief Resident

SYSTEMS BASED PRACTICE

PGY 1	PGY 2	PGY 3
• Acts as a Patient Advocate • Begins the Mastery of Global Health Care Delivery • Begins to Understand Health Insurance Mechanisms	• Works with Ancillary Team Members to Provide In Hospital and Post-Discharge Care	• Understands and Can Provide Cost Effective Care • Understands Basics of Billing and Coding Issues

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

IM RESIDENCY SUPERVISION POLICY

PURPOSE:

The Internal Medicine Residency Program recognizes and supports the importance of graded and progressive responsibility in graduate medical education. This policy outlines the requirements to be followed when supervising residents. The goal is to promote assurance of safe patient care, and the resident's maximum development of the skills, knowledge, and attitudes needed to enter the unsupervised practice of medicine. The Program Director is responsible for monitoring and enforcing the supervision policy at all sites. Monitoring is done by resident feedback directly and on surveys as well as faculty education. **(VII.A.2.)*** There are four (4) levels of supervision recognized.

1. Direct: The supervising physician is physically present with the resident and the patient and is prepared to take over the provision of patient care if/as needed. **(VI.A.2.c).(1)***

2. Indirect supervision with direct supervision immediately available:
   The supervising physician is present in the hospital (or other site of patient care) and is immediately available to provide Direct Supervision. The supervisor may not be engaged in any activities (such as a patient care procedure) which would delay his/her response to a resident requiring direct supervision. **(VI.A.2.c).(2).(a)***

3. Indirect supervision with direct supervision available: The supervising physician is not required to be present in the hospital or site of patient care, or may be in-house but engaged in other patient care activities, but is immediately available through telephone or other electronic modalities, and can be summoned to provide Direct Supervision. **(VI.A.2.c).(2).(b)***

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

Scope: All Internal Medicine Residents

PROCEDURE:

1. Residents on inpatient ward rotation relate to a maximum of four attending physicians, the equivalent of a weekly change, on each rotation.

2. The IM Residency establishes schedules which assign qualified faculty physicians, Fellows or Senior Residents to supervise at all times and in all settings in which Internal Medicine residents provide any type of patient care. The type of supervision to be provided is delineated in the curriculum's rotation description and/or the graduate levels of responsibility.

3. The minimum amount/type of supervision required in each situation is determined by the

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

definition of the type of supervision specified, but is tailored specifically to the demonstrated skills, knowledge, and ability of the individual resident. In all cases, the faculty member functioning as a supervising physician should delegate portions of the patient's care to the resident, based on the needs of the patient and the skills of the resident as well as the privileges of the attending physician.

4. Senior residents and fellows serve in a direct or indirect supervisory role of junior residents in recognition of their progress toward independence.

5. All residents, regardless of year of training, must communicate with the appropriate supervising faculty member any changes in condition of the patient is highlighted in the rotation guidelines.

6. In every level of supervision, the supervising faculty member must review progress notes, sign procedural and operative notes and discharge summaries.

7. Faculty members must be continuously present to provide supervision in ambulatory settings, and be actively involved in the provision of care, as assigned.

8. Residents on Internal Medicine inpatient rotations are never supervised by a resident from another specialty unless it is procedural assistance.

LINES OF RESPONSIBILITY

Ultimate supervision responsibility for patient care rests with the medical attending physician. A medical attending physician is readily available 24 hours per day for resident consultation based on published schedules for the rotation. Medical attending physicians must:

- Review all resident orders
- Make frequent progress notes and approve all changes in the level of care
- Approve diagnostic studies
- Sign all histories and physicals
- Sign discharge summaries

Graded responsibility for the ward team within 24 hours of admission is given to PGY-II and PGY-III supervisory residents and to the Chief Resident. They are responsible for the quality of care provided by their unit. Interns and residents are responsible for first-physician contact responsibility. When the complexity of needed services exceeds the capability of both the senior resident and the medical Chief Resident, the back-up system is activated or the appropriate qualified medical attending physician is contacted.

Residents are given progressive responsibility for the care of patients. The resident can act as a teaching assistant to less experienced residents. Assignment of the level of responsibility is commensurate with their acquisition of knowledge and development of judgment and skill; and is consistent with the requirements of the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

The determination of a resident's ability to accept responsibility for performing procedures or activities without a supervisor present and/or act as a teaching assistant is based on documented evidence of the resident's clinical experience, judgment, knowledge and technical skills. Such evidence is obtained through competency checklist and successful performance of the required number of directly supervised procedures as outlined in the procedure logger software. The resident is then considered competent to perform procedures with indirect supervision. The supervising attending physician must have privileges to perform the procedure under all circumstances regardless of the level of supervision required by the resident physician.

Documentation of a resident's assigned level of responsibility is filed in the resident's record which is maintained in the office of the Program Coordinator. Documentation is also supplied to each teaching institution as well as the GME Office via the resident's ability to show their competence in procedure logger software.

Even though the resident is acting as a teaching assistant, the medical attending remains responsible for the quality of care of the patient, providing adequate supervision and meeting medical record documentation requirements.

All residents are responsible for assuring all medical records are completed in accordance to the Medical Staff policies of the assigned rotation facility. ***If medical records are not completed at the end of the rotation, residents may be asked to take annual leave for the purpose of completing discharge summaries and other paperwork***. Residents are given guidelines to complete the records on day of discharge or at a maximum within 24 hours after. Attending/Chief Residents will monitor and issues will be brought to program administration.

Care should be taken to eliminate or minimize responsibility of residents to perform routine clerical functions such as scheduling tests and appointments and retrieving records and letters. Site specific guidelines are present at each sites orientation.

CARE OF NON-TEACHING PATIENTS

Residents will be responsible for the care of patients on the teaching service only. If concerns or issues arise regarding care of non-teaching patients, please contact the attending and the program director. Exceptions to the rule involve emergent "code blue" situation. Care for non-teaching service patients in these situations should return to their attending physician as soon as available.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Contacting Faculty Regarding "Must Call" Patient Care Policy

Purpose:

There are situations when it is required that residents be in contact with faculty regarding patient care:

- Admissions and discharges (especially unexpected discharges)
- Inpatient transfers to higher level of care
- Consultations with other physicians
- Major changes in a patient's condition
- Planned invasive procedure
- Uncertainty regarding the diagnosis
- Critical care time spent (>15 minutes patient care time of admitted patient)

Policy:

Attending physicians are available for guidance 24 hours a day. The resident should call with any discomfort regarding a patient's status or the need for guidance with management issues of both new and established patients.

Scope: All IM Residents and Faculty

Specific Points of Change in Patient Status:

The following criteria are adapted from ICU transfer guidelines. If a patient has one of the following conditions, you must contact your attending physician.

- Hemodynamic change that is not responsive to treatment, (e.g. fluid challenge) for example a pulse <50 or >130 or SBP <88
- Urine output <20cc an hour unresponsive to therapy
- Acidosis with pH<7.2
- Complicated MI, CHF or arrhythmia
- Multisystem organ failure
- Severe GI bleed
- Sustained change in level of consciousness
- New hypoxemia
- Hyperkalemia refractory to treatment
- Unexpected death

Updated 5/2018

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

ORDER ENTRY POLICY

(IV.C.3.g).(7)

Residents should enter most of the orders for patients under their care, with appropriate supervision by the attending physician. In unusual circumstances when an attending physician or subspecialty resident writes an order on a resident's patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner.

Proficiency in usage of all participating sites Electronic Health Record is an expectation. Proper utilization of each participating sites approved Medical Staff Order Sets is required.

PATIENT SUPERVISION BY RESIDENTS

On Inpatient rotations:

First-year residents: **(IV.C.3.g).(1-3)***

- 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 medical services.
- Must not be assigned more than ***eight new patients in a 48***-hour period.
- Must not be responsible for the ***ongoing care of more*** than ***ten*** patients.
- Should interact with second-year or third-year internal medicine residents in the care of patients.

Second-year and third-year residents: **(IV.C.3.g).(4-6)***

- When supervising ***more than one*** first-year resident, the supervising resident must not be responsible for the supervision or admission of ***more than ten new patients and four transfer patients per admitting day*** or more ***than 16 new patients in a 48-hour*** period.
- When supervising **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.

    - First-year residents should interact with second and third-year internal medicine residents in the care of patients as a general rule unless an Attending is assuming the direct supervision role.
    - Senior internal medicine residents or other appropriate supervisory physicians must be available at all times on site to supervise first-year residents.
    - Residents should have continuing responsibility for most of the patients they admit.
    - Residents from other specialties must not supervised IM residents on any IM inpatient rotation.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

PGY 1 GRADUATED LEARNING RESPONSIBILITES
Internal Medicine Residency
Quillen College of Medicine

Resident's Name:

PGY Level: 1

Date:

I. Patient Care Objectives

A. Interviewing: Interns must demonstrate the importance of communication when caring for patients as they collect highly personal information by:

- Consistently demonstrate integrity, respect, compassion and empathy for patients and their families
- Establish trust and recognize the primary concern is the welfare of the patient
- Respect personal preferences and understand patient rights
- Engage in shared decision making with their patients

B. History taking: Interns must demonstrate an understanding of the importance of history in deriving a differential diagnosis by:

- Consistently gathering essential and accurate information
- Organize documentation in a manner consistent with accepted medical convention and charted in a timely and efficient manner
- Information should be comprehensive and include data gathered by other providers, previous imaging and laboratory investigations

C. Physical Examination: Interns will demonstrate the importance of performing an appropriate and relevant physical exam by:

- Performing a comprehensive physical exam with a resident
- Identify normal from abnormal and will describe the physiological and anatomical basis for these findings
- Demonstrate the ability to augment their physical exam steps to elicit data not obtained with standard movements

D. Clinical Judgment, Medical Decision-Making and Management Plans: Interns will progressively become more adept at assimilating information that they have gathered from the history and physical exam by:

- Identifying all the patients' problems
- Developing a prioritized differential diagnosis
- Understand their limitation of knowledge and seek the advice of more advanced clinicians

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

- Beginning to develop therapeutic plans that are evidenced or consensus based
- Establishing an orderly succession of testing based on their history and exam findings
- Demonstrate cost effective use of diagnostic/therapeutic procedures

E. Oral Case Presentation Skills: Residents at all levels of training will be adept in oral presentation skills demonstrated by:

- Delivering an appropriately focused case presentation that is well organized
- Including all-important aspects of the history, physical exam, and laboratory investigations
- Well developed and include an in-depth differential diagnosis and plans for carefully executed diagnostic and therapeutic plan
- Becoming progressively more sophisticated at distilling relevant information
- Pertinent materials such as x-rays and EKG's will be included and correctly interpreted

F. Patient /Family Education:
Interns will be skilled at:

- Giving patients accurate instructions regarding usage of their medications and follow-up care
- Documenting their counseling conversations

G. Use of Technology: Interns will understand the increasing role that technological advancements bring to the bedside by:

- Demonstrating the usage of computer-assisted databases for diagnosis and decision-making
- Utilizing the electronic medical record
- Regularly utilizing drug information programs

H. Procedures: Interns will understand the importance of competently performing medical procedures essential for the practice of general internal medicine by:

- Demonstrating knowledge of procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care
- Participating in informed consent and assist the patient with decision making through their knowledge
- Procedures are documented by residents in New Innovations and confirmed by their preceptor. Interns will be supervised for all procedures. By the end of the first year, Interns will have successfully completed the following procedures:

Procedure	Number required	Competent
Arterial Blood Draw or Gas	5	0
Venous Blood Draw	5	0
Pap Smear/Endocervical Culture	5	0
Venous Peripheral Catheter	5	0

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

II. Medical Knowledge Specific Competency Objectives

Interns 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. Interns are expected to:

A. Know and apply the basic and clinically supportive sciences that are appropriate to their discipline. Interns will:

- Demonstrate knowledge of common procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care
- Demonstrate knowledge of basic and clinical sciences
- Demonstrate satisfactory knowledge of common medical conditions, sufficient to manage urgent complaints with supervision
- Exhibit sufficient content knowledge of common conditions to provide care with minimal supervision by completion of the PGY-1 year
- Take the USMLE Step 3 exam by June 30th of the academic year
- Pass the USMLE Step 3 exam, with documentation of passing grade provided to Residency Office

B. Demonstrate an investigatory and analytic approach to clinical situations
PGY-1 residents will:

- Exhibit utilization of the University and hospital library resources
- Exhibit self-motivation to learn
- Demonstrate sufficient analytic skills necessary to develop appropriate assessments and plans for common medical diagnoses and complaints
- Demonstrate ability to frame clinical questions and initiate literature search
- Regularly display self-initiative to stay current with new medical knowledge
- Independently present current scientific evidence to support hypotheses
- Prepare a scholarly work either local, regional or national

III. Practice Based Learning and Improvement Specific Competency Objectives

The ability to utilize clinical practice and direct patient care as a venue for practice improvement and learning is a lifelong process; however, it is expected that all levels of resident will satisfactorily function in the following areas:

A. Evidence Based Medicine:

- Location, appraisal, and assimilation of evidence from scientific studies related to patients' health problems
- Application of knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- All residents should demonstrate the ability to be self-motivated to acquire knowledge
- Locate scientific literature to support decision-making

B. Information Technology:

- Use information technology to manage information, access on-line medical

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

information and support their own education

C. Teaching:

- Facilitation of learning of students, resident colleagues, and other health care professionals

IV. Interpersonal and Communication Skills Objectives

Interns should:

A. Communication:

- Provide appropriately succinct oral presentations regarding patient care, using appropriate medical terminology
- Develop skills in presenting at the bedside
- Provide timely thorough and complete written or electronic documentation of patient care (*e.g.*, progress or procedure notes, history and physical exams, consultant notes, discharge summaries), which are legible and use appropriate medical terminology
- Demonstrate proficiency in use of language and nonverbal skills in interactions outside of the context of patient care
- Establish rapport with patients from a variety of backgrounds
- Perform a medical interview that elicits both patient- and physician-centered information, as well as testing diagnostic hypotheses
- Effectively communicate uncomplicated diagnostic and therapeutic plans to patients or their advocates

B. Ethically sound relationships: Follow the tenets of ethics in patient care.

C. Working within teams:

- Work as team members with senior residents and attending physicians, including the communication skills outlined above and the coordination of patient care
- When supervising medical students, Interns should be able to observe students, demonstrate skills, actively involve students in patient care, and give constructive feedback
- Work effectively with ancillary staff to enhance patient care

V. Systems Based Practice Objectives

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.

Interns are expected to:

A. Reflect on 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 affect their own practice.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Interns should:

- Display ability to work well within their core clinical team, including other residents/attending physicians/directly involved nurses/respiratory therapists/other professionals involved in the care of their assigned patients.

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

- Actively participate in discharge planning sessions
- Attend educational sessions relating to different types of medical practice and delivery systems

C. Practice cost-effective health care and resource allocation that does not compromise quality of care. Interns must:

- Reflect sensitivity to costs and be able to incorporate fundamental cost-effective analysis into care approaches, minimizing redundant or unnecessary care.

D. Advocate for quality patient care and assist patients in dealing with system complexities. Interns must:

- Demonstrate commitment and dedication to high quality patient care
- Identify, implement, document, and monitor established local patient care plans that are consistent with nationally published clinical practice guidelines

E. Know how to collaborate with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance. Interns must:

- Demonstrate the ability to regularly and effectively work with the patient care coordinators/discharge coordinator, social workers, and other health care professionals to assess, coordinate, and improve patient care.

F. Perform One (1) activity of volunteer work offered or approved by program every academic year.

This approved form will remain in force for a period of one year from the promotion date, or until an updated form is issued.

_____ _____

Residency Program Director Date Signature of Resident Date

cc: Resident File
GME Office
Teaching Institutions

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

PGY 2 GRADUATED LEARNING RESPONSIBILITIES
Internal Medicine Residency
Quillen College of Medicine

Resident's Name:

PGY Level: 2

Date:

I. Patient Care Objectives

A. Interviewing: Residents must demonstrate the importance of communication when caring for patients as they collect highly personal information by:

- Consistently demonstrate integrity, respect, compassion and empathy for patients and their families
- Establish trust and recognize the primary concern is the welfare of the patient
- Respect personal preferences and understand patient rights
- Engage in shared decision making with their patients

PGY-2 residents should demonstrate the above and aid junior peers in effective communication with patients.

B. History taking: Residents must demonstrate an understanding of the importance of history in deriving a differential diagnosis by:

- Consistently gathering essential and accurate information
- Organize documentation in a manner consistent with accepted medical convention and charted in a timely and efficient manner
- Information should be comprehensive and include data gathered by other providers, previous imaging and laboratory investigations

PGY-2 Residents will:

- Be precise, logical, and efficient in their data collection
- Demonstrate progressive skills in hypothesis driven histories

C. *Physical Examination:* Residents will demonstrate the importance of performing an appropriate and relevant physical exam by:

- Performing a comprehensive physical exam with a resident
- Identify normal from abnormal and will describe the physiological and anatomical basis for these findings
- Demonstrate the ability to augment their physical exam steps to elicit data not obtained with standard movements

PGY-2 Residents will:

- Correctly detect subtle findings and understand their significance
- Teach appropriate physical exam skills to junior peers and medical students

D. Clinical Judgment, Medical Decision-Making and Management Plans: Residents will progressively become more adept at assimilating information that they have gathered from the history and physical exam by:

- Identifying all the patients' problems
- Developing a prioritized differential diagnosis
- Understand their limitation of knowledge and seek the advice of more advanced clinicians
- Beginning to develop therapeutic plans that are evidenced or consensus based
- Establishing an orderly succession of testing based on their history and exam findings
- Demonstrate cost effective use of diagnostic/therapeutic procedures

PGY-2 residents will:

- Integrate medical facts and clinical data while weighing alternatives and keeping in mind patient preference
- Incorporate consideration of costs, risks, and benefits when considering testing and therapies.
- Present up-to-date scientific evidence to support their hypotheses
- Use information technology effectively to support patient care decisions and strive to provide cost effective care
- Monitor and follow-up patients appropriately
- Enlist social and other out-of-hospital clinical resources to help patients with the therapeutic plan
- Assist junior trainees and medical students to become efficient managers through the appropriate use of clinical judgment and effective decision-making

E. Oral Case Presentation Skills: Residents at all levels of training will be adept in oral presentation skills. This will be demonstrated by:

- Delivering an appropriately focused case presentation that is well organized
- Including all-important aspects of the history, physical exam, and laboratory investigations
- Well developed and include an in-depth differential diagnosis and plans for carefully executed diagnostic and therapeutic plan
- Becoming progressively more sophisticated at distilling relevant information
- Pertinent materials such as x-rays and EKG's will be included and correctly interpreted

F. Patient /Family Education:
Residents will be skilled at:

- Giving patients accurate instructions regarding usage of their medications and follow-up care
- Documenting their counseling conversations

PGY-2 residents will:

- Effectively counsel and educate patients about pertinent health issues, tests and treatments
- Recommend appropriate screening exams by gender and age
- Consistently and thoroughly educate patients and their families, using patient education as a form of intervention and partnering

G. Use of Technology: Residents will understand the increasing role that technological advancements bring to the bedside by:

- Demonstrating the usage of computer-assisted databases for diagnosis and decision-making
- Utilizing the electronic medical record
- Regularly utilizing drug information programs

PGY-2 residents will:

- Utilize electronic databases for patient educational materials
- Demonstrate the ability to perform a literature search of available databases as needed to facilitate patient care and their own learning

H. Procedures: All residents will understand the importance of competently performing medical procedures essential

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

for general internal medicine by:

- Demonstrating knowledge of procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care
- Participating in informed consent and assist the patient with decision making through their knowledge
- Procedures are documented by residents in New Innovations and confirmed by their preceptor.

PGY-2 residents will:

- Demonstrate extensive knowledge and be facile in the performance of procedures. By the end of the PGY-2 year, residents will have successfully completed the following procedures.

Procedure	Number required	Competent
Arterial Blood Draw or Gas	5	0
Venous Blood Draw	5	0
Pap Smear/Endocervical Culture	5	0
Venous Peripheral Catheter	5	0

II. Medical Knowledge Specific Competency Objectives

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:

A. Know and apply the basic and clinically supportive sciences which are appropriate to their discipline.
All senior residents will:

- Demonstrate knowledge of common procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care
- Demonstrate knowledge of basic and clinical sciences
- Demonstrate satisfactory knowledge of common medical conditions, sufficient to manage urgent complaints with supervision
- Exhibit sufficient content knowledge of common conditions to provide care with minimal supervision by completion of the PGY-2 year

PGY-2 residents will:

- Demonstrate a progression in content knowledge and analytical thinking in order to develop well-formulated differential diagnoses for multi-problem patients
- Demonstrate understanding and responsiveness to socio-behavioral issues
- Develop knowledge of statistical principles
- Understand and appropriately use sensitivity, specificity, predictive values, likelihood ratio, number needed to treat, and odds ratios
- Demonstrate knowledge regarding the performance of procedures while minimizing risk and discomfort to patients
- Exhibit knowledge of effective teaching and evaluation methods

B. Demonstrate an investigatory and analytic approach to clinical situations.
Senior residents will:

- Exhibit utilization of the University and hospital library resources
- Exhibit self-motivation to learn
- Demonstrate sufficient analytic skills necessary to develop appropriate assessments and plans for common medical diagnoses and complaints

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

- Demonstrate ability to frame clinical questions and initiate literature search
- Regularly display self-initiative to stay current with new medical knowledge
- Independently present current scientific evidence to support hypotheses
- Prepare a scholarly work either local, regional or national

III. Practice Based Learning and Improvement Specific Competency Objectives

The ability to utilize clinical practice and direct patient care as a venue for practice improvement and learning is a lifelong process; however it is expected that all levels of resident will satisfactorily function in the following areas:

A. Evidence Based Medicine:

- Location, appraisal, and assimilation of evidence from scientific studies related to patients' health problems
- Application of knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- All residents should demonstrate the ability to be self-motivated to acquire knowledge
- Locate scientific literature to support decision-making

PGY-2 residents will:

- Appraise and assimilate scientific literature
- Demonstrate understanding and use of an evidence- based approach in providing patient care
- Quickly access appropriate reference material for critically ill patients
- Voluntarily (without prompting or assignment) discuss and research relevant literature to support decision- making processes
- Acquire and use appropriate evidence-based information when acting as a consultant
- Learn and be able to research non-internal medicine patient care issues

B. Information Technology:

- Use information technology to manage information, access on-line medical information and support their own education
- Use the EMR, web-based curricular modules, and web-based resources to access medical literature and data to support and enhance patient care

PGY-2 residents will:

- Use Health Links and other computerized connections to primary literature to enhance patient care

C. Teaching:

- Facilitation of learning of students, resident colleagues, and other health care professionals

PGY-2 residents will:

- Facilitate education of PGY-1 residents, medical students, and other health care professionals
- Demonstrate evidence based independent research and preparation when teaching junior colleagues or peers
- Use interactions with nursing staff and other professionals as two-way educational opportunities

IV. Interpersonal and Communication Skills Objectives

All residents should:

A. Communication:

- Provide appropriately succinct oral presentations regarding patient care, using appropriate medical

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

terminology
- Develop skills in presenting at the bedside
- Provide timely thorough and complete written or electronic documentation of patient care (*e.g.*, progress or procedure notes, history and physical exams, consultant notes, discharge summaries), which are legible and use appropriate medical terminology
- Demonstrate proficiency in use of language and nonverbal skills in interactions outside of the context of patient care
- Establish rapport with patients from a variety of backgrounds
- Perform a medical interview that elicits both patient- and physician-centered information, as well as testing diagnostic hypotheses
- Effectively communicate uncomplicated diagnostic and therapeutic plans to patients or their advocates

B. Ethically sound relationships: Follow the tenets of ethics in patient care.

C. Working within teams:
- Work as team members with senior residents and attending physicians, including the communication skills outlined above and the coordination of patient care
- When supervising medical students and first year residents, Senior residents should be able to observe, demonstrate skills, actively involve others in patient care, and give constructive feedback
- Work effectively with ancillary staff to enhance patient care

PGY-2 residents, in addition to the above, should further master the skills below:

Patient Communication:
- Engage patients in shared decision making for ambiguous or controversial scenarios
- Conduct family meetings as in the setting of end of life decision making
- Successfully negotiate most "difficult" patient encounters, such as the irate patient

Team Work:
- Progressively assume a leadership role, facilitating interactions between junior residents, medical students, ancillary staff, and attending physicians
- Establish expectations for all members of the team, overseeing patient care, ensuring participation in academic discussions, etc.
- Be the primary team members interacting with specialists regarding consults, and notifying outpatient primary care physicians of their patients' hospital courses

V. Systems Based Practice Objectives

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:

A. Reflect on 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 affect their own practice.
Senior residents should:
- Display ability to work well within their core clinical team, including other residents/attending

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

physicians/directly involved nurses/respiratory therapists/other professionals involved in the care of their assigned patients
- Work well with multidisciplinary teams, coordinating multi-specialty care and effectively working with case management and nursing in team settings such as family meetings and large team discussions
- Provide and document care in a timely and thorough manner to facilitate analysis of practice patterns and use of information by other health care professionals

B. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources. All residents must:
- Actively participate in discharge planning sessions
- Attend educational sessions relating to different types of medical practice and delivery systems

PGY-2 residents will:
- Demonstrate a satisfactory level of understanding regarding medical practice and delivery systems, including alternative care resources, ambulatory care resources, rehabilitation resources, and other continuing care resource
- Understand methods of controlling health care costs and appropriate allocation of resources

C. Practice cost-effective health care and resource allocation that does not compromise quality of care.
Residents must:
- Reflect sensitivity to costs and be able to incorporate fundamental cost-effective analysis into care approaches, minimizing redundant or unnecessary care

D. Advocate for quality patient care and assist patients in dealing with system complexities.
All senior residents must:
- Demonstrate commitment and dedication to high quality patient care
- Identify, implement, document, and monitor established local patient care plans that are consistent with nationally published clinical practice guidelines
- Be able to effectively guide patients needing assistance through the complex health care environment

E. 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. All senior residents must:
- Demonstrate ability to regularly and effectively work with the patient care coordinators/discharge coordinator, social workers, and other health care professionals to assess, coordinate, and improve patient care
- Reflect understanding of the benefits of such partnering activities on the operation of the health care system
- Regularly and effectively work with case managers, utilization review personnel, physician assistants, ambulatory staff, and other providers within the larger health care system

F. Perform (1) activity of volunteer work offered or approved by program.

This approved form will remain in force for a period of one year from the promotion date, or until an updated form is issued.

Residency Program Director Date	**Signature of Resident Date**

cc: Resident File
GME Office
Teaching Institutions

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

PGY 3 GRADUATED LEARNING RESPONSIBILITIES
Internal Medicine Residency
Quillen College of Medicine

Resident's Name:

PGY Level: 3

Date:

1. Patient Care Objectives

A. Interviewing: Residents must demonstrate the importance of communication when caring for patients as they collect highly personal information by:

- Consistently demonstrate integrity, respect, compassion and empathy for patients and their families
- Establish trust and recognize the primary concern is the welfare of the patient
- Respect personal preferences and understand patient rights
- Engage in shared decision making with their patients
- Aid junior peers in effective communication with patients

B. History taking: Residents must demonstrate an understanding of the importance of history in deriving a differential diagnosis by:

- Consistently gathering essential and accurate information
- Organize documentation in a manner consistent with accepted medical convention and charted in a timely and efficient manner
- Information should be comprehensive and include data gathered by other providers, previous imaging and laboratory investigations
- Be precise, logical, and efficient in their data collection
- Demonstrate progressive skills in hypothesis driven histories

C. Physical Examination: Residents will demonstrate the importance of performing an appropriate and relevant physical exam by:

- Performing a comprehensive physical exam with a resident
- Identify normal from abnormal and will describe the physiological and anatomical basis for these findings
- Demonstrate the ability to augment their physical exam steps to elicit data not obtained with standard movements
- Correctly detect subtle findings and understand their significance
- Teach appropriate physical exam skills to junior peers and medical students
- Perform a focused physical exam at the level similar to a sub-specialist
- Understand the sensitivity and specificity of these maneuvers

D. Clinical Judgment, Medical Decision-Making and Management Plans: Residents will progressively become more adept at assimilating information that they have gathered from the history and physical exam by:

- Identifying all the patients' problems
- Developing a prioritized differential diagnosis
- Understand their limitation of knowledge and seek the advice of more advanced clinicians

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

- Beginning to develop therapeutic plans that are evidenced or consensus based
- Establishing an orderly succession of testing based on their history and exam findings
- Demonstrate cost effective use of diagnostic/therapeutic procedures
- Integrate medical facts and clinical data while weighing alternatives and keeping in mind patient preference
- Incorporate consideration of costs, risks, and benefits when considering testing and therapies.
- Present up-to-date scientific evidence to support their hypotheses
- Use information technology effectively to support patient care decisions and strive to provide cost effective care
- Monitor and follow-up patients appropriately
- Enlist social and other out-of-hospital clinical resources to help patients with the therapeutic plan
- Assist junior trainees and medical students to become efficient managers through the appropriate use of clinical judgment and effective decision-making
- Demonstrate appropriate reasoning in ambiguous situations, while continuing to seek clarity
- PGY 3 residents will not overly rely on tests and procedures
- Consistently establish monitoring procedures and demonstrate the ability to change therapeutic programs for ineffectiveness or adverse side effects

E. Oral Case Presentation Skills: Residents at all levels of training will be adept in oral presentation skills. This will be demonstrated by:

- Delivering an appropriately focused case presentation that is well organized
- Including all-important aspects of the history, physical exam, and laboratory investigations
- Well developed and include an in-depth differential diagnosis and plans for carefully executed diagnostic and therapeutic plan
- Becoming progressively more sophisticated at distilling relevant information
- Pertinent materials such as x-rays and EKG's will be included and correctly interpreted

F. Patient/Family Education:
All residents will be skilled at:

- Giving patients accurate instructions regarding usage of their medications and follow-up care
- Documenting their counseling conversations
- Effectively counsel and educate patients about pertinent health issues, tests and treatments
- Recommend appropriate screening exams by gender and age
- Consistently and thoroughly educate patients and their families, using patient education as a form of intervention and partnering

G. Use of Technology: Residents will understand the increasing role that technological advancements bring to the bedside by:

- Demonstrate the usage of computer-assisted databases for diagnosis and decision-making
- Utilize the electronic medical record
- Regularly utilizing drug information programs
- Utilize electronic databases for patient educational materials
- Demonstrate the ability to perform a literature search of available databases as needed to facilitate patient care and their own learning

H. Procedures: All residents will understand the importance of competently performing medical procedures essential for general internal medicine by:

- Demonstrate knowledge of procedural indications, contraindications, necessary equipment, process

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

for handling specimens and patient after-care
- Participate in informed consent and assist the patient with decision making through their knowledge
- Procedures are documented by residents in New Innovations and confirmed by preceptor
- Demonstrate extensive knowledge and be facile in the performance of procedures

By the end of the PGY-3 year, residents will have successfully completed the following procedures.

ABIM/ACGME Procedures	Number required	Competent
Arterial Blood Draw/Arterial Blood Gas	5	0
Pap Smear /Endocervical Culture	5	0
Venous Blood Draw	5	0
Venous Peripheral Catheter	5	0

Residents are encouraged to have become competent in the following procedures, either with direct patient care or sim lab training.

Performed Procedures	Number encouraged	Competent
Arterial Line Placement	5	0
Arthrocentesis	5	0
Central Venous Line Placement	5	0
Incision & Drainage of Abscess	5	0
Lumbar Puncture	5	0
Nasogastric Intubation	5	0
Paracentesis	5	0
Thoracentesis	5	0

II. Medical Knowledge Specific Competency Objectives

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:

A. Know and apply the basic and clinically supportive sciences which are appropriate to their discipline by:
- Demonstrate knowledge of common procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care
- Demonstrate knowledge of basic and clinical sciences
- Demonstrate satisfactory knowledge of common medical conditions, sufficient to manage urgent complaints with supervision
- Exhibit sufficient content knowledge of common conditions to provide care with minimal supervision
- Demonstrate a progression in content knowledge and analytical thinking in order to develop well-formulated differential diagnoses for multi-problem patients
- Demonstrate understanding and responsiveness to socio-behavioral issues
- Develop knowledge of statistical principles
- Understand and appropriately use sensitivity, specificity, predictive values, likelihood ratio, number needed to treat, and odds ratios
- Demonstrate knowledge regarding the performance of procedures while minimizing risk and discomfort

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

to patients
- Exhibit knowledge of effective teaching and evaluation methods

B. Demonstrate an investigatory and analytic approach to clinical situations.
Senior residents will:
- Exhibit utilization of the University and hospital library resources
- Exhibit self-motivation to learn
- Demonstrate sufficient analytic skills necessary to develop appropriate assessments and plans for common medical diagnoses and complaints
- Demonstrate ability to frame clinical questions and initiate literature search
- Regularly display self-initiative to stay current with new medical knowledge
- Independently present current scientific evidence to support hypotheses
- Regularly demonstrate knowledge of the impact of study design on validity or applicability to individual practice
- Prepare their second scholarly work

III. Practice Based Learning and Improvement Specific Competency Objectives

The ability to utilize clinical practice and direct patient care as a venue for practice improvement and learning is a lifelong process; however it is expected that all levels of resident will satisfactorily function in the following areas:
A. Evidence Based Medicine:
- Location, appraisal, and assimilation of evidence from scientific studies related to patients' health problems
- Application of knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness

B. *Information Technology*:
- Use information technology to manage information, access on-line medical information and support their own education
- Use the EMR, web-based curricular modules, and web-based resources to access medical literature and data to support and enhance patient care

C. Teaching: Facilitation of learning of students, resident colleagues, and other health care professionals
PGY-3 residents should additionally:
- Facilitation of learning of students, resident colleagues, and other health care professionals
- Facilitate education of PGY-1 residents, medical students, and other health care professionals
- Demonstrate evidence based independent research and preparation when teaching junior colleagues or peers
- Use interactions with nursing staff and other professionals as two-way educational opportunities

IV. Interpersonal and Communication Skills Objectives
All residents should:

A. Communication:
- Provide appropriately succinct oral presentations regarding patient care, using appropriate medical terminology
- Develop skills in presenting at the bedside
- Provide timely thorough and complete written or electronic documentation of patient care (*e.g.*,

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

progress or procedure notes, history and physical exams, consultant notes, discharge summaries), which are legible and use appropriate medical terminology
- Demonstrate proficiency in use of language and nonverbal skills in interactions outside of the context of patient care
- Establish rapport with patients from a variety of backgrounds
- Perform a medical interview that elicits both patient- and physician-centered information, as well as testing diagnostic hypotheses
- Effectively communicate uncomplicated diagnostic and therapeutic plans to patients or their advocates

B. Ethically sound relationships: Follow the tenets of ethics in patient care.

C. Working within teams:
- Work as team members with senior residents and attending physicians, including the communication skills outlined above and the coordination of patient care
- When supervising medical students and first year residents, Senior residents should be able to observe, demonstrate skills, actively involve others in patient care, and give constructive feedback
- Work effectively with ancillary staff to enhance patient care

Patient Communication:
- Engage patients in shared decision making for ambiguous or controversial scenarios
- Conduct family meetings as in the setting of end of life decision making
- Successfully negotiate most "difficult" patient encounters, such as the irate patient

In addition to the above, PGY 3 residents should be able to successfully negotiation nearly all "difficult" patient encounters with minimal direction.

Team Work:
- Progressively assume a leadership role, facilitating interactions between junior residents, medical students, ancillary staff, and attending physicians
- Establish expectations for all members of the team, overseeing patient care, ensuring participation in academic discussions, etc.
- Be the primary team members interacting with specialists regarding consults, and notifying outpatient primary care physicians of their patients' hospital courses

In addition to above, PGY 3 residents should function as team leaders with decreasing reliance upon attending physicians. They should be able to function as consultants (including completion of appropriate documentation and verbal communication with the requesting physician per residency policies) whether serving as a general medicine consultant to other services or when on elective rotations.

V. Systems Based Practice Objectives

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:
A. Reflect on 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 affect their own practice.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

- Display ability to work well within their core clinical team, including other residents/attending physicians/directly involved nurses/respiratory therapists/other professionals involved in the care of their assigned patients
- Work well with multidisciplinary teams, coordinating multi-specialty care and effectively working with case management and nursing in team settings such as family meetings and large team discussions
- Provide and document care in a timely and thorough manner to facilitate analysis of practice patterns and use of information by other health care professionals
- Demonstrate a high level of understanding regarding medical practice and delivery systems, including methods of controlling health care costs and appropriate allocation of resources

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

- Actively participate in discharge planning sessions
- Attend educational sessions relating to different types of medical practice and delivery systems
- Demonstrate a satisfactory level of understanding regarding medical practice and delivery systems, including alternative care resources, ambulatory care resources, rehabilitation resources, and other continuing care resource
- Understand methods of controlling health care costs and appropriate allocation of resources
- Strive to appropriately contain costs and conserve limited resources while preserving a high quality of care

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

- Reflect sensitivity to costs and be able to incorporate fundamental cost-effective analysis into care approaches, minimizing redundant or unnecessary care
- Act as team leader during interdisciplinary Family Meetings regarding complex patient care needs

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

- Demonstrate commitment and dedication to high quality patient care
- Identify, implement, document, and monitor established local patient care plans that are consistent with nationally published clinical practice guidelines
- Be able to effectively guide patients needing assistance through the complex health care environment
- Act as team leader during interdisciplinary Family Meetings regarding complex patient care needs

E. 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.

- Demonstrate ability to regularly and effectively work with the patient care coordinators/discharge coordinator, social workers, and other health care professionals to assess, coordinate, and improve patient care
- Reflect understanding of the benefits of such partnering activities on the operation of the health care system
- Regularly and effectively work with case managers, utilization review personnel, physician assistants, ambulatory staff, and other providers within the larger health care system

By completion of the PGY 3 year, resident should also be able to identify and act on improvement opportunities for healthcare system through partnerships with case managers and other providers.

F. Perform (1) activity of volunteer work offered or approved by program.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

This approved form will remain in force for a period of one year from the promotion date, or until an updated form is issued.

Residency Program Director	**Date**	**Signature of Resident**	**Date**

cc: Resident File
GME Office
Teaching Institutions

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

PROMOTION OF RESIDENTS

Residents are promoted to the next training level based on meeting milestones/competency standards as set forth by the Accreditation Council for Graduate Medical Education, (ACGME), and American Board of Internal Medicine, (ABIM). Recommendations for promotion will be determined by the Program Director and the Clinical Competency Committee, (CCC).

After approval for advancement by the CCC, a Graduated-Level of Responsibility form and a promotion form will be submitted to the Program Director for approval and signature as well as to the resident for acknowledgement. The signed form is kept in the resident's file and the GLR form updated when additional credentialing is successfully completed and confirmed. These Graduated-Levels of Responsibility forms with procedure logger are also sent to each teaching institution and to the GME Office to assist with credentialing and procedure performance.

5/2018

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

INTERNAL MEDICINE RESIDENCY EVALUATION PROCESS

Purpose:

To address the processes for conducting all ACGME required evaluations for the IM Residency Program.

Policy:

The ETSU Quillen College of Medicine Internal Medicine Residency Program utilizes New Innovations™ as an electronic evaluation tool. In addition, the program may utilize paper evaluations for certain types of evaluators. In accordance with ACGME Common Program Requirements programs must follow the evaluation criteria outlined below.

Scope: All IM Faculty, Residents and Residency Staff

Procedure:

A. Resident Evaluations (V.A.1)*

1. The faculty evaluates the resident's performance in a timely manner during each rotation or similar educational assignment and documents this evaluation at completion of the assignment. New Innovations™ is utilized to meet this requirement.
2. The program provides objective assessments of the resident's ***competency in the 6 ACGME core competency categories***: **(V.A.1.c)***
    - patient care & procedural skills
    - medical knowledge
    - practice- based learning and improvement
    - interpersonal and communication skills
    - professionalism
    - systems-based practice
3. In addition to faculty, the program tracks residents' performance utilizing multiple evaluators and evaluation tools. (Peers, patients, other professional staff (nursing) and self-evaluations.
4. Utilizing New Innovations™, the program documents, track and trends progressive resident performance appropriate to educational level. As appropriate, individualized performance improvement plans are developed for residents whose evaluations indicate the need. **(V.A.1.d).(3)***
5. Semiannual reviews of all internal medicine residents will be conducted by the Program Director or an Associate Program Director. These semiannual reviews will be standardized and if applicable will include at a minimum: **(V.A.1.d)***
    - Monthly Rotation Evaluations (Faculty and Peer)
    - Quarterly Patient and Nursing Feedback

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

- Direct Observation Methods
- Self-Evaluation
- In Training Exam scores
- Longitudinal Board Review Scores/Mock Board Exam Scores/Milestone Reports
- Scholarly Activity
- Resident's well-being
- Future Plans
- Feedback regarding the Program

6. Residents have access to their evaluations through New Innovations™ and by requesting their evaluation file located in the IM Residency Office.
7. Residents who make satisfactory or above progress as determined by the Program Director and the Program Evaluation Committee will be promoted to the next level of residency and given increased responsibilities.

B. Residents Summative Evaluation (V.A.2)*

1. The Program Director must provide a summative evaluation for each resident upon completion of the program. This summative evaluation, (The Credentialing/Verification Form) becomes part of the resident's permanent record and is accessible for review by the resident and is utilized by the department as part of the credentialing process when information is requested. **(V.A.2.a).(2))***
2. The Credentialing/Verification Form documents the residents' performance during the final period of education. The form also verifies that the resident has demonstrated sufficient competence to enter practice without direct supervision as well as qualifies them to apply for the ABIM Board Certification.

C. Faculty Evaluation (V.B)*

The Internal Medicine Department evaluates faculty performance as it relates to the educational program at ***least annually***. **(V.B.1)*** Faculty Member prepares and Academic Faculty report which is reviewed with the Chair.

1. Clinical Teaching (Medical Students and Residents)
2. CME/Scholarly Activity
3. Research/Grant Activity
4. Faculty Leadership/ Awards/Recognition
5. Clinical Knowledge/Patient Care Service
6. Administrative Service (Professionalism and Committee Responsibilities)
7. Professional Organization Membership

This is a part of the Internal Medicine's FAP, FAR, FAE process. The Residency Office generates a report that includes the residents' evaluation of faculty for this process.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Faculty requirements **(II.B)***

At Each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must also demonstrate a strong interest in the education of residents by administering and maintaining an educational environment conducive to educations residents in each of the ACGME competency areas.

Faculty is expected to provide advising for residents in the areas of educational goalsetting, career planning, patient care, and scholarship while meeting professional standards of behavior.

The physician faculty must have current certification in the specialty by the American Board of Internal Medicine, or possess qualifications judged acceptable to the Review Committee. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

The faculty must regularly participate in organized clinical discussions, rounds, journal clubs and conferences.

Some members of the faculty should also demonstrate scholarship by one or more of the following:

1. Peer-reviewed funding,
2. Publication of original research or review article in peer reviewed journals or charters in textbooks,
3. Publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings,
4. Participation in national committees or educational organizations.

D. Program Evaluation (V.C.)*

The Internal Medicine Residency Program must document formal, systematic evaluation of the curriculum annually. The program must also monitor residents' performance, faculty development, graduate performance and program quality which is specifically assessed by annual confidential evaluations by residents and faculty as part of the Program Evaluation Committee, (PEC). This Committee meets at least quarterly with one meeting dedicated to the Annual Program Evaluation (APE).

Agenda items include:

1. Rotating calendar for review of each PGY level residents' performance. This review includes assessment of the educational effectiveness of inpatient and ambulatory teaching based outcomes, six ACGME core competencies and the goals and objectives of the rotations
2. Faculty Development
3. In-Training Exams and Graduate Performance on the ABIM Certification Exam
4. Review of Action Plan Progress
5. Program Quality

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

The Program Evaluation Committee, chaired by the Program Director, is responsible for addressing any deficiencies (opportunities for improvement) identified by the program's annual assessment performed by the residents, Internal Reviews, ACGME Residents' Survey, and the annual review of the program goals and objectives. Formal Action Plans are developed to include measurable outcomes if possible.

Appeal of a Negative Evaluation

If a resident receives an evaluation considered unfair, the resident may put in writing why he/she feels the evaluation is unfair. The resident will meet the Program Director (PD) or Associate Program Director (APD).

The PD may call a meeting with attending physician who submitted the evaluation, the resident, and the PD for adjudication. If additional adjudication is required, the resident will meet with entire Program Evaluation Committee.

Review New Innovations™ Evaluation Module. Also see examples of evaluations included in the IM Resident Handbook.

Updated 5/2018

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

QCOM Internal Medicine Residency
Responsibilities of the Program Evaluation Committee
(V.C.)*

The Quillen College of Medicine, Internal Medicine Residency's Program Evaluation Committee (PEC) provides a formal structure to be used in program evaluation, design and improvement. This committee is crucial in ensuring the quality of the residency program.

Membership:
The QCOM IM PEC is composed of the Program Director, and the Associate Program Directors, one of which will serve as committee chair. Additionally, resident representatives from each level of training are appointed. Committee members will acquire an understanding in basic quality improvement principles and the relationship of quality improvement and patient safety. The PEC will meet quarterly with one meeting being devoted to the Annual Program Evaluation, (APE).

Responsibilities: (V.C.1.b)*
The IM PEC must participate in the planning, developing, implementing, and evaluating all significant activities of the residency. This includes but is not limited to resident performance, faculty development, graduate performance and program quality.

The PEC will conduct and document a formal, systematic evaluation of the program with each APE. Documentation will include a written plan of action for any deficiencies identified. This plan of action will be monitored for progress as part of the standing agenda for each meeting. The Annual Program Review will include but is not limited to:

- Overall performance of residents (e.g., in-service exam results, procedure logs, summary evaluations of housestaff) **(V.C1.c.(6)***
- Faculty development (e.g., CME activities, activities directed toward improving teaching abilities and professionalism, ACGME Faculty Survey) **(V.C.1.c).(7).(b)***
- Graduate performance **(V.C.1.c).(6).(d)***
- Confidential written Resident evaluation of the Program (e.g., ACGME Resident Survey, resident evaluation of rotations) **(V.C.2.d).(1)***
- Confidential written faculty evaluation of the Program (e.g. Faculty Survey)
- The previous year's improvement action plan to evaluate whether the identified improvements were achieved. **(V.C.2.e)***

The PEC will oversee or appoint representative program personnel to develop and evaluate the competency – based curriculum goals and objective and the effectiveness with which they are achieved. The PEC will review, revise and approve IM specific policies and will ensure that both, QCOM GME policies and program policies are implemented.

The PEC will conduct the Annual Program Review during the annual Committee Meeting which must include all components listed below.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

1. The ***Annual Program Review*** must include a review of the following: **(V.C.3.)***
    - Overall performance of house staff (e.g., in-service exam results, procedure logs, summary evaluations of housestaff)
    - Faculty development (e.g., CME activities, activities directed toward improving teaching abilities and professionalism)
    - Graduate performance (e.g., certification examination results, survey of graduates)
    - Confidential written housestaff evaluation of the Program
    - Confidential written faculty evaluation of the Program
    - The previous year's improvement action plan to evaluate whether the identified improvements were achieved.
2. Based on the review and evaluation, the Committee shall prepare a written improvement plan of action for the Program.
3. The Committee must maintain written meeting minutes. These minutes must include the written improvement plan of action for the upcoming year.
4. The Program Improvement Plan of Action must be presented to and approved by the Program's faculty. **(V.C.1.e)***
5. After approval, all program updates will be entered into the ACGME ADS system. **(V.C.3.f)***

Current Program Evaluation Committee Members for Academic Year 2018-2019

Dr. Jonathan Moorman, Vice Chair of Education, Research and Scholarship
Dr. James Myers, Program Director
Dr. Diana Nunley, Associate Program Director
Dr. Debalina Das, Associate Program Director
Dr. Matt Parks, VA ACOS of Education
Dr. Vijay Ramu, Cardiology Division Chief
Dr. Jeff Summers, Department Chairman
PGY1 Representative (Dr. Sumbal Babar)
PGY2 Representative (Dr. Bara El Kurdi)
PGY3 Representative (Dr. Laith Almomani)

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

QUILLEN COLLEGE OF MEDICINE
INTERNAL MEDICINE RESIDENCY PROGRAM
(II.A.4.a).(14)*

CONFIDENTIAL VERIFICATION AND REFERENCE FOR:
Name: «FirstName» «MI» «LastName», «Suffix»

This confidential document relating to a former resident is provided to you by East Tennessee State University, James H. Quillen College of Medicine, and Internal Medicine Residency Program. This document is being submitted in response to your request for verification of residency training in Internal Medicine and reference information in lieu of other forms. The original **notarized signature** of the current program director will verify its authenticity. The contents of this document are provided with the permission of the named physician and should not be released to any other party without the consent of that physician.

I. **Verification of Training:**

- ☐ Dr. «LastName» successfully completed his/her ACGME Accredited Internal Medicine residency training at East Tennessee State University, James H. Quillen College of Medicine as follows: **Training Start Date:**_____ **Training End Date:** _____
- ❑ See comments, Item I.

II. **Disciplinary Action:**

- ❑ During the dates of training at this institution, Dr. «LastName» was not subject to any institutional disciplinary action, such as admonition, reprimand, suspension, probation or termination.
- ❑ See comments, Item II.

III. **Professional Liability:**

- ❑ To the best of our knowledge, Dr. «LastName» was not investigated by any governmental or other legal body and was not the defendant in any malpractice suit during residency training.
- ❑ See comments, Item III.

IV. **Ability to Practice Medicine:**

- ❑ To the best of our knowledge, no conditions exist that would impair Dr. «LastName»'s ability to practice Internal Medicine.
- ❑ See comments, Item IV.

V. **Clinical Privileges/Procedures Requested:**

- ❑ The education Dr. «LastName» received from our training program was sufficient for the practice of Internal Medicine competently and independently. Dr. «LastName» was recommended for the certifying examination administered by the American Board of Internal Medicine.
- ❑ If requested, a copy of the resident's procedure logger will be attached.

VI.

Evaluation: The following is derived from a composite of multiple evaluations by supervisors in this resident's rotations during **his or her** residency training. The evaluation is based upon the Accreditation Council for Graduate Medical Education (ACGME) General Competencies, which define the essential components of clinical competence. In cases where the definition of the competency could be unclear, the ACGME definition is given after the table.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

	Unsatisfactory	Satisfactory	Superior	No Knowledge
Medical Knowledge				
Patient Care				
Interviewing				
Physical Examination				
Procedures				
Professionalism				
Communication and Interpersonal Skills				
Practice Based Learning and Improvement**				
Systems Based Practice ***				

** Residents receiving a satisfactory evaluation in Practice Based Learning perform satisfactory investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

*** Residents receiving a satisfactory evaluation in Systems Based Practice 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.

Comments:

VII. **Recommendation:**
Based on a composite evaluation by the East Tennessee State University, James H. Quillen College of Medicine Department of Internal Medicine, Dr. «LastName» is recommended to you as of the **30th day of June, 201** .

Internal Medicine Program Director

VIII. ☐ I have reviewed this evaluation with the program director or designee. I understand that this form will, in most cases, be utilized as the confidential verification and reference form in lieu of other forms when requests for verification of resident training and/or reference are received by the Department of Internal Medicine.

«FirstName» «MI» «LastName», «Suffix»

IX. ☐ Resident reviewed the evaluation but chose not to sign.

Internal Medicine Program Director

X. ☐ Resident did not review the evaluation.

Internal Medicine Program Director

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

RESOLUTION OF RESIDENT INITIATED GRIEVANCES

(II.A.4.a).(10)*

It is desirable for resident's concerns regarding the program, physical impairment, fatigue, or quality impairment, etc. to be resolved within the departmental structure. There are multiple ways that concerns can be expressed by the residents:

1. Suggestion box at both clinic sites
2. Anonymous hotline
3. Town Hall meeting monthly with resident representative report
4. Attending physician
5. Chief residents
6. Program Administration

When resolution is not obtained the resident's grievance regarding the residency program should be expressed to his/her preceptor, Program Director, Department Chair, or any other faculty member or administrative officer of the College of Medicine, who will help to resolve the issue or agree on further action.

If not resolved, the problem then will be brought by the involved resident and appropriate faculty member to the attention of the resident's program director and the Executive Associate Dean for Clinical Affairs.

If there is still no resolution of the problem, the Executive Associate Dean for Clinical Affairs will convene an ad-hoc committee and proceed with the due process.

If the resident's grievance is against the Executive Associate Dean for Clinical Affairs, program director, department chair of any clinical department, or any other person who might otherwise take part in the process of resolving the problem, the above steps will be structured to exclude the involvement of that person from the judging process.

If resolution cannot be achieved using the above process, the Dean of the College of Medicine will be the final authority.

Residents are encouraged to immediately report concerns or policy violations and not wait for national evaluations that provide little specific information about concerns.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

UNSATISFACTORY PERFORMANCE BY A RESIDENT/FELLOW

The purpose of this policy is to describe the process used by the program to address residents who fail to meet performance or academic standards for the Internal Medicine program. It is the policy of the program to employ procedural fairness in all matters which may lead to probation, suspension or termination. Residents/fellows who experience a deviation from expected performance will be identified in a timely manner by the Program Director and the Program Evaluation Committee.

A resident/fellow deemed to be deficient in any aspect of his/her performance will be given verbal and written notification and, if warranted, may be placed on departmental Performance Improvement Plan (PIP). Departmental probation is utilized when it is anticipated that there will be a successful remediation on the part of the resident/fellow. The probationary period will be left to the discretion of the Program Director, but generally will be three to six months.

When such action occurs, the Program Director will inform the resident/fellow in writing of the deficiencies in academic or clinical performance which were noted to include core competencies and/or milestones that encompass the problem. A written plan of improvement will be developed for the resident/fellow with the program director. The written plan will include the length of departmental probation. When necessary this approach will include the appointment of one or more faculty to work with the resident/fellow on a regular basis using a planned individual format. For problems admitted to involve psychiatric or substance abuse issues, efforts to obtain appropriate counseling/psychotherapy will be required. Anytime a resident/fellow is removed from his/her clinical duties the office of the Executive Associate Dean for Graduate Medical Education must be notified as soon as possible.

If the resident/fellow does not satisfactorily remediate deficiencies during the departmental PIP period or if, in the Program Director's opinion, the resident/fellow's original deficiency may result in termination, the resident/fellow will be placed on institutional probation, generally not to exceed three months without re-evaluation. Again, the resident/fellow must be notified in writing of the deficiencies, remediation, and length of the institutional probation. The resident/fellow must also be notified in writing of the possibility that the institutional probation may lead to termination form the program. The Office of the Executive Associate Dean for Graduate Medical Education must be notified in writing by the Program Director when a resident/fellow is placed on institutional probation.

At the end of the probationary period the resident/fellow's performance will be reassessed and the resident/fellow will be notified in writing as to his/her status. The resident/fellow may be removed from probation if the stated deficiencies have been remediated, or the probation may be continued if the resident/fellow's performance has improved but deficiencies remain or new deficiencies uncovered; or the resident/fellow may be terminated. The resident/fellow is notified in writing as to the reasons for termination. The Program Director also notifies the Office of the Executive Associate Dean for Graduate Medical Education of the termination.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Definitions:

Probation: Probation shall be used for residents who are in jeopardy of not successfully completing the requirements of the program or who are not performing or behaving satisfactorily. Conditions of probation shall be communicated to residents in writing and should include: the reason(s) for probation, an individualized action plan, and the expected timeframe for the required remediation. Failure to correct the deficiency in the expected timeframe may lead to an extension of the probationary period. The probationary period should ***not be less than 30 days*** and its duration should be appropriate for the issue(s) of concern.

Suspension: Residents may be suspended from part or all usual and regular assignments, including clinical and/or didactic duties for failure to comply with the program's or the participating sites' policies. Suspensions are confirmed in writing, stating the reason(s) for the suspension and its expected duration. Suspensions generally do not exceed ***60 calendar days*** and may be coupled or followed by other actions. The GME has the discretion of assigning suspension with or without pay.

Termination: Residents who have not satisfactorily improved in the areas discussed during the remediation and/or probation process as determined by the Clinical Competency Committee will be terminated from the program. If additional incidents or concerns arise during a period of probation or suspension and are found to be valid after review by the Clinical Competency Committee, the resident will be terminated from the program at that time. The resident has the right to appeal this decision and seek due process as set forth by the GME handbook.
http://www.etsu.edu/com/gme/current_resources/handbook.php

Procedure:

1) The IM Clinical Competency Committee will serve as the committee to review concerns, probation, suspension or termination. The Program Director will provide the CCC with documentation of the concerns that led to the disciplinary action which will include previous meetings with the resident and prior efforts to counsel the resident. Depending of the gravity of the concern or disciplinary action, the resident may provide the CCC with a written statement explaining why they feel the concern or disciplinary action is not warranted. The CCC meets quarterly and has a standing agenda for reviews of concern. If necessary, depending of the gravity (suspension or termination), the program leadership may have a called meeting of the CCC to review disciplinary actions. The CCC may request to meet with the resident following the review of documentation. The CCC will render a decision to uphold the original action or to request an alternate action, which will include an appropriate course of remediation or a personal improvement plan. The resident will receive written notification of the CCC's decision within **10 working** days. The decision of the CCC will be final unless the resident files a Due Process as outlined in the GME Due Process policy.

2) Program leadership will work with the Associate Dean of GME regarding any resident being placed on probation, suspension or terminated. This notification will include a written statement describing the problem, warnings issued, deliberations of the CCC and the proposed resolution.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

This notification must occur prior to the program taking final action and before informing the resident of the decision.

3) The GME office and the legal department must determine whether the action is reported to State or Federal Authorities, as applicable.

4) Program Leadership must provide a specific statement to the resident as the action taken, effect on salary, benefits and training certification.

    a) In cases of termination, salary and benefits shall be terminated as of the effective date, and training certification shall be granted for the period of months of acceptable service. Health insurance coverage may be maintained under COBRA options so as to provide continuous health care coverage, in which case the resident is responsible for all premiums.

    b) A suspension may be imposed with or without pay, and shall result in suspension of training credit during interruption of service. In instances of suspension with pay, benefits coverage shall be continued during the period of suspension. The resident suspended without pay shall be responsible for full premiums of the benefits during the suspension period.

    c) A non-renewal will result in termination of the resident's employment and associated benefits at the end of their academic year contract.

Updated 5/2018

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

INDIVIDUALIZED REMEDIATION PLAN FOR INTERNAL MEDICINE RESIDENTS

Name:_____ Date:_____

Check (X) Level: □ PGY1 □ PGY2 □ PGY3

PROBLEM(S): Check (X) applicable problem area(s) and provide description.

□ Professionalism □ Clinical Judgment □ Medical Knowledge
□Interpersonal/Communication Skills □ Other

Description of the problem(s):

_____
_____
_____
_____

REMEDIATION PLAN

Time allotted for remediation: □1 month □3 months □6 months □1 year
Date begun: _____ Date complete: _____

Summary of remediation planned, in process, or undertaken (e.g. increased supervision, repeated rotation(s), psychiatric consultation):

_____
_____
_____
_____

Person(s) responsible for determining type of remediation:

□ Program Director
□ Associate Program Director
□ Competency Committee
□ Faculty Advisor
□ Other

Person(s) responsible for implementing remediation:

□ Program Director
□ Associate Program Director
□ Competency Committee
□ Faculty Advisor
□ Other

Person(s) responsible for assessing decision and outcome:

□ Program Director
□ Associate Program Director
□ Competency Committee
□ Faculty Advisor
□ Other

DECISION/OUTCOME:

□ Successful resolution of problem
□ Remediation still in process
□ Unresponsive to remediation
□ Needs different remediation
□ Termination

I have read and understand the remediation plan and have also signed and been provided a copy of the contract for the Performance Improvement Program.

RESIDENT SIGNATURE: _____ DATE: _____

FACULTY SIGNATURE: _____ DATE: _____

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Internal Medicine Performance Improvement Agreement

I, _____, MD___, understand that, based upon a number of metrics as assessed by the Clinical Competence Committee and leadership of the Internal Medicine residency program, I have been identified as "at risk" for failing the ABIM Internal Medicine certifying examination following completion of my residency program. I understand that a number of resources are being provided to me by my Department so I may improve my performance and knowledge base in internal medicine, and improve my chances of becoming an ABIM-certified internist. I agree with the importance of this goal and commit to put forth my best efforts to effect this improvement.

To this end, I agree to fully participate in the Performance Improvement Program prepared for me by my program directors. This will include full, scheduled completion of the USMLEWorld question bank program (R2, R3 and R4 residents), and may include additional study groups, presentations and other educational enhancement measures identified for me. I understand that my regular duty assignments, including conference attendance and clinical rotation assignments, will continue during this period. I understand that my failure to fully participate in this program will result in my being placed on academic probation, at which time I will be required to perform formal remediation and pass additional metrics to avoid termination from the residency.

_____ _____

(Resident Signature) (Date)

Updated 5/2018

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

TERMINATION OF A RESIDENT/FELLOW

Termination of a resident/fellow may occur based on two situations:

1. Unacceptable behavior serious enough to call for immediate temporary or permanent suspension. This action may be taken when the resident/fellow's performance endangers the health or safety of others, or, for any other reason is deemed unacceptable by the Program Director, Chair and/or the Associate Dean of GME; or

2. Failure to meet expected milestones despite a carefully planned remediation program.

INSTITUTIONAL POLICY ON HOSPITAL SUSPENSION OF A RESIDENT/FELLOW

The affiliated hospital administration may find cause to suspend a resident/fellow from clinical activities. When such a suspension occurs, the hospital administration will immediately notify the appropriate departmental chair and program director. Within ***five working days*** the program director will convene a committee of ***two departmental faculty*** selected by the program director and ***two representatives from the involved hospital*** selected by the hospital administration. This committee, chaired by the program director, will investigate the incident and recommend appropriate action to the departmental chair. Such action will also be communicated to the hospital administration representative in charge of graduate medical education. If the hospital administration is not agreeable with the committee's recommendation to the chair, the issue will be submitted to the Executive Associate Dean for Graduate Medical Education. If agreement can still not be reached with the hospital administration, the issue will be referred to the Dean of the College of Medicine and the CEO of the appropriate hospital. The ultimate decision regarding resident/fellow clinical privileges shall be made by the Hospital. VA issues will be handled according to Veteran's Administration Policies. Program Administration should be notified immediately of action to be taken to ensure that the resident can be informed of their rights.

If the resident/fellow disagrees with the final recommended action, the resident/fellow has access to the grievance process outlined in the grievance policy.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

DUE PROCESS AND TERMINATION OF A RESIDENT/FELLOW

This outline of Due Process is applicable to any resident/fellow who wishes to appeal an adverse decision by his/her program director or departmental chair. Adverse actions include: non-renewal of contract; suspension from residency program; termination for residency program; imposition of limitation on resident/fellow's professional responsibilities; or imposition of disciplinary action resulting from violation of residency policy or procedure.

The house staff shall consist of resident/fellows and clinical fellows regularly appointed at the James H. Quillen College of Medicine, East Tennessee State University. Its members shall be under the supervision of the department in which they are appointed.

The members of the house staff shall abide by the rules and regulations set by the program directors, the hospitals and the Dean. Failure of a member of the house staff to perform his/her duties or to abide by the College of Medicine and the affiliated hospitals rules and regulations shall be reported to his/her departmental chair and/or program director. The department shall then institute appropriate disciplinary action.

A member of the house staff who wishes to appeal an adverse decision by his/her program director or department chair may appeal the decision of the department and request a hearing before an ad hoc committee. This committee shall consist of ***not less than five faculty members and two resident/fellows to be appointed by the Dean.*** The five faculty members ***will be from specialties other than those represented by the resident/fellow and will have little or no personal involvement with the resident/fellow's instruction or evaluation***. One of the two resident/fellow representatives will be selected from a list supplied by the resident/fellow making the appeal and the other selected from the Chief Resident/fellows Committee. The Executive Associate Dean for Graduate Medical Education will chair the committee. In the event that the Executive Associate Dean for Graduate Medical Education is involved in the hearing, the Dean will appoint a chair. The committee shall convene a hearing at a date agreeable to all parties, ***but in no case more than four weeks after receiving the written request for the appeal***. Committee witnesses will include those on a list provided by the resident/fellow to speak in his/her behalf. The committee will also request testimony from those in the program responsible for evaluations and decisions which led to an adverse action. The ad hoc committee may request from the department copies of all evaluations and documents leading to an adverse action. The resident/fellow making the appeal has the right to have an advocate present. *The advocate cannot be an attorney*. This advocate is present only to advise the resident/fellow and may not participate in the process. The resident/fellow has the right to hear all witnesses and to ask any questions under the direction of the chair of the ad hoc committee. An electronic recording of the proceedings may be made, but only for the purpose of producing a written transcript; at which time all recordings will be destroyed. This transcript and all other records related to the appeal will be available to the appellant upon request. The chair of the committee will not have a vote in the committee's decision, but will submit his/her recommendation along with the recommendations of the committee to the Dean. The decision of the Associate Dean and Dean is final.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

CLOSER/REDUCTION POLICY

The College of Medicine Graduate Medical Education Program recognized the need and benefits of graduate medical education and sponsors training programs which emphasize personal, clinical, and professional development. The College of Medicine residency programs are conducted in substantial institutional and program requirements of the ACGME and its individual Residency Review Committees.

In the event the College of Medicine has to reduce the number of positions in or closes a residency training program, the College of Medicine will notify the GMEC, DIO, and residents in training as soon as possible. If possible, reductions will be made over a period of time to allow all residents to complete training. In the event that an ACGME action or decreased financial or educational resources force the closure of a training program, the College of Medicine will allow the residents already in the program to complete their education or assist them in locating another ACGME accredited program in which they can continue their education.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

IM Residency Travel Policy

Purpose:

The involvement of residents in travel related to educational activities is necessary and encouraged. **(IV.B.2)*** Because such travel can result in absences from clinical duties and also results in numerous expenses, a number of conditions must be met before such travel will be supported. Residents submitting abstracts must notify the residency office that an abstract is being submitted. Once an oral or poster presentation is accepted by regional or national medical associations, the resident must meet with Program Administrator in the residency office to begin the travel authorization paperwork and request education leave.

Note: Travel Authorization must be approved for all Education Leave travel even if the Department is not funding the travel.

Procedure:

1. Residents may use the annual education allotment or travel, both as a presenter and an attendee. Funding may only be used for registration, hotel, transportation and meals as outlined in the ETSU Travel Policy: https://www.etsu.edu/bf/fp/07.php

2. Residents may also use their allotted Education Fund Money for conference attendance. Residents utilizing their individual funds for conference attendance not associated with presentations must have Education Leave approved by the Program Director and must follow the same travel authorization process. The VAMC will only pay for 5 days of Educational Leave per year. The VA ACOS (Matt Parks, MD) must approve this leave request a minimum of 30 days in advance. **(IV.D.1.b)***

3. Criteria for Scholarly Activity Approval:

- **A.** The reason for travel is to present an oral or poster presentation.
- **B.** The traveling resident will personally make the presentation.
- **C.** Time away from clinical duties is minimized. Residents are expected to arrange their own back-up if possible and inform the chief resident, attending and fellow team members of the coverage arrangements. The back-up system may be used if necessary.
- **D.** Residents must schedule a time to present to residency program prior to travel.

4. Criteria for Conference Attendance Approval:

- **A.** Request to attend a major conference for the purpose of education and networking should be submitted with consideration to the residents' clinical duty assignment. Requests for travel during a ward month is discouraged and will be made on a

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

case by case basis must include a proposal for coverage which does not include the use of back-up. Residents can utilize their individual education fund money for this travel.

B. Education Leave must be approved by the Program Director.

C. Registration for the conference should ***only be done*** after the resident has met with the IM Residency Program Administrator.

5. Authorization for travel:

A. A copy of your approved Educational Leave ***must accompany*** your official ETSU Travel Authorization Form.

B. The request will be submitted in the following order: Program Administrator, who will then have the Program Director and Chairman approve the request.

6. Reimbursement of Travel Expenses:

A. Residents will not be reimbursed if the approval of travel was ***not obtained thirty days*** prior to the date of departure. There will be no exceptions.

B. Travel reimbursement from must be submitted and signed by resident no more than 30 days from travel return date. Travel reimbursement forms submitted more than 30 days after travel return date will not be paid.

7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Internal Medicine Resident Forum Meetings
"Town Hall"

PURPOSE:

The IM Residency Forum meetings serve as a voice for all residents to address and prioritize concerns related to the residency program.

POLICY:

The Resident Forum meetings are available to all residents in the program and are facilitated by the peer elected resident representatives and the PGY IV Chief Residents. With the exception of the chief residents, there will be no program leadership in attendance unless they have been formally invited to participate. These meetings will be held several times per year at noon during the Academic Half Day.

SCOPE: IM Residents

PROCEDURE:

1. The Peer Elected Residency Representative and the PGY IV Chief Residents will coordinate all aspects of the Resident Forum meetings. These include but are not limited to:
   a. Development of an agenda
   b. Facilitation of the Meeting
   c. Distribution of the minutes
   d. Arranging follow-up meetings with the Program Director to share opportunities for improvement that require Program Leadership action.

2. In addition to identifying opportunities for improvement, the Resident Forum meetings allow residents to:
   a. Recommend new policies and procedures.
   b. Identify Quality and Patient Safety issues from all training sites.
   c. Request guest speakers
   d. Plan social events.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Internal Medicine Residency Education Allotment Policy

Purpose:

In addition to salary and benefits, the Internal Medicine Residency Program allots each resident an annual education allowance.

Scope: All residents and fellows

Procedure:

1. Each resident and fellow is allowed an annual educational allotment of $500 for educational material or travel as per university policy. An additional $500 will be available for travel for conference presentations. The Department of Internal Medicine program determines how the funds can be used based on year of training and program policies. **No funds can be carried over from one fiscal year to the next**. (July 1 – June 30)

2. The funds are allotted for the purchase of medical books, professional memberships, professional licensing fees, tablets such as an iPad (limited to one during entire training period), software, study materials and/or to offset attendance at regional or national meetings as an attendee or a presenter.
   Note: laptops and phones are not allowable purchases.

3. Residents may choose to use the educational allocation for registration fees for USMLE/COMLEX Step 3 or ABIM Board certification.

4. If funding is used for travel, the Internal Medicine Residency Travel policy must be followed as well as the guidelines set forth by the University and outlined in Financial Procedure FP-7 which can be found at https://www.etsu.edu/bf/fp/07.php

5. If funds are to be used for educational materials it is preferable for residents to contact the residency office to request and manage the purchase. The residency office will process these requests and deduct the total amount from the individual residents education allocation account.

6. If the resident does purchase education material or travels, all original receipts must be presented to the residency office. Travel must be reconciled completely with the request for reimbursement. Receipts for educational material purchased by the resident must be presented to the residency office. The office will complete the request for reimbursement and send to the GME office for processing.

7. Note: Reimbursement for computers and professional registration fees ***are taxable*** in accordance with the IRS.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Residency Leave Policy

Purpose:
The American Board of Internal Medicine requires all internal medicine trainees to successfully complete 11 out of 12 months each year of training for a total of 33 in a 3-year period in order to be eligible for the internal medicine board exam. If a resident's total leave time (including annual leave, administrative leave, leave without pay, and medical leave) exceeds 1 month per year, promotion to the next level or your graduation date can be delayed. Excessive leave time will need to have a specific plan developed. Approval from the program must be obtained to extend residency because of ACGME and funding restrictions for number of residents. ***Also, note that training must be completed by August 31 in order to be eligible for the board exam offered after graduation year.***

Policy:

As outlined in the University Resident Handbook, residents/fellows are allowed:

1. Three weeks' Vacation/ Annual Leave - 15 working days – per academic year. Weekends and Holidays do not count. Check with your rotation preceptor to see if a particular holiday applies to the assigned rotation.
2. 12 Sick Days per academic year
3. 5 Administrative Days total in 3 years
4. Educational Leave as approved by the Program Director

No more than five working days of leave may be scheduled during any four-week and one working day during any two-week block rotation. In general, residents will not be approved for more than one away activity during a rotation (vacation, conference leave, CME activity, etc.) as this often adversely affects both the educational and patient care continuity of the rotations.

Go here to access ABIM's Leave of Absence and Vacation Policies

Scope: All IM Residents

Procedure by Leave Type:

II. Vacation/Annual Leave

1. Residents are REQUIRED to submit vacation leave requests for their two-week block of vacation during the spring "lottery" for the following academic year. Incoming residents must comply with the same requirements. Schedules will be completed by May of the current academic year. The remaining five days may be used in a block or as single days. These must be submitted for approval at least 30 days in advance. Failure to meet this prescribed time frame can result in denial of leave.
2. Leave is granted based on level of training and/or first-come, first approved policy.
3. Leave requests are not considered approved until the resident receives approval from the

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

residency office. Arrangements and purchase of tickets or fees SHOULD NOT occur until the resident receives notification of leave approval. Failure to follow the policy resulting in monetary loss is the responsibility of the resident.

4. No leave for travel outside of the US will be approved during the final 60 days of a currently valid non-resident visa until the visa has been approved.
5. For overseas travel, residents must understand the risk of travel delays and the potential of lengthening the residency duration required to meet the ABIM requirements.
6. For those residents who must renew their visa status, this should be accomplished during planned vacations. Additional time off will not be granted for visa renewal.
7. If a resident is delayed by more than 60 days from returning to his/her residency assignments because of travel outside of the US, his/her status as a resident in the Internal Medicine Residency of ETSU can be terminated. Resumption of residency will require reapplication for admission to the IM Residency Program and is not guaranteed.
8. Residents MAY NOT schedule vacations during Inpatient Medicine, Night Medicine, Critical Care, or during the first month or the last 2 weeks of the Academic year if not graduating. Leave during the Clinic rotation is described in that section.
9. Unused annual leave by University policy is forfeited at the end of each academic year. Residents are encouraged to utilize their vacation time.

III. Sick Leave

1. Sick Leave is approved for up to 12 working days per year and shall accumulate with the unused amount of sick leave carried forward.
2. Sick leave with pay may be taken when sickness, injury, or pregnancy prevents the resident's/fellow's performance of duty or according to FMLA guidelines. http://www.etsu.edu/humanres/documents/ppps/ppp46_family_medical_servicemember_leave.pdf
3. Residents/Fellows are not paid for unused sick leave.
4. If you are out due to illness, even if you "called-in sick" and received verbal permission, you MUST submit a form request at the latest the first day you return to duty.
5. Residents/Fellows are required to notify the chief residents, rotation and clinical attendings, and administrative staff as soon as possible when unexpected absence from duty due to illness AND must submit a Leave Request Form.
6. The resident/fellow must provide a health care provider's statement to return to duty for periods of sick leave of two consecutive work days or longer. This must be provided to the Program Coordinator.
7. If a resident/fellow shows a pattern of reporting in sick on Monday, Friday, or prior to or after a holiday, or under any other circumstances deemed unusual by program staff, the Program Director may require documentation from the resident's or fellow's physician to justify the absence.
8. If Sick Leave is taken during AHD, it requires a doctor's excuse.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

9. Residents are encouraged to develop a primary care physician as soon as possible during their residency. Residents should not request treatment from colleagues or attending physicians outside a scheduled appointment.

IV. Family Leave

Residents/Fellows are entitled to the provisions of the Family Medical Leave Act of 1993. This leave is without pay, but use of accrued sick and vacation leave may be used as part of the family leave. In order to be considered eligible under the FMLA guidelines, a resident/fellow must (1) have worked for the University for at least 12 months; and (2) have worked at least 1,250 hours during the year preceding the start of the leave. Eligible residents/fellows may take Family and Medical Leave for the birth of a child and the care of such newborn child; for the placement of a child with the resident/fellow for adoption or foster care; for the care of the resident's spouse, child, or parent who has a serious health condition; or for the fellow's own serious health condition that prevents him/her from performing the essential functions of his/her position. Residents/Fellows should be aware that this time will not be counted toward board eligibility. The Program Director and resident/fellow will be responsible for establishing a make-up schedule in compliance with the Board requirements of the particular specialty.
If a husband and wife are both residents/fellows and are eligible for Family and Medical Leave, the total number of work weeks of leave for birth, adoption, and foster care placement to which both are entitled is limited to 12 work weeks.

V. Maternity & Paternity Leave

Maternity and Paternity leave may be taken out of accumulated sick leave, vacation time, or leave without pay in the event the resident/fellow has not met the eligibility requirements for FMLA. Please refer to the University Resident Handbook. Excessive leave will extend the period of residency. As with all sick leave, all female residents/fellows, returning to work after the birth of a child, must submit to the Residency/Fellowship Office, a release from their physician before returning to work.

VI. Leave of Absence, Military Leave, and Bereavement Leave

Please refer to the University Resident Handbook.

VII. Leave for Interview Dates

1. Each resident/fellow applying for fellowships or employment may take up to total of ***five administrative*** leave days for interviews during entire residency/fellowship with PRIOR APPROVAL by the Program Director.
2. Additionally, residents may utilize their annual leave or leave without pay for interviews after all leave is exhausted. Use of educational leave for interviews is not permitted. If annual leave is to be utilized, residents must obtain the signature of the Program Director as previously stated in this policy.
3. The Residency/Fellowship Program understands that invitations for fellowship interviews

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

often occur with little advanced notice and offer only a single or limited number of days to interview. Employment interviewing typically offers more flexible scheduling. Residents should negotiate job interview times with employment recruiters around elective rotations. Recruiters are very much aware of resident's clinical responsibilities and are accustomed to scheduling dates to accommodate residents. If the resident must schedule an interview during a ward month, then the resident must exhaust all possibilities for coverage before contacting the PGY IV chief for use of the back-up schedule. All back up coverage MUST be paid back.

4. As soon as an invitation is received, the resident/fellow must contact the Chief, supervising attending and continuity clinic.
5. Residents/Fellows must have sufficient administrative or annual leave days available; no additional leave will be granted. Residents anticipating the need for fellowship interview leave should schedule their leave periods accordingly.
6. A leave request must be submitted and approved.
7. The resident is responsible for coordinating with the PGY IV Chief/Lead Resident to arrange coverage for patient care during absences.

VIII. Leave for Presentations at Regional and National Meetings (Educational Leave)

1. With Program Director's approval, educational leave may be used for conference presentation travel and for required exams and or recertification.
2. If accepted for presentation and if approved by the sponsoring Division Chief resident may be provided travel and presentation material reimbursement.
3. Once accepted at a national meeting, the same submission must not be resubmitted for regional conferences.
4. A travel request MUST be filled out for any resident going to a conference or an away rotation – even if the university is not paying for the travel – this is for liability coverage.
5. An arrangement for appropriate continuation of patient care duties in his/her absence is the responsibility of the presenting resident and must be approved by the PGY IV chiefs.
6. Third year residents are eligible for up to 5 days of education leave out of the allotment to attend a Board Review course. The leave request must include a copy of the paid receipt for the course.

IX. Leave Request Process

NO verbal requests – All leave must be submitted and approved through the proper process.

1. Leave for vacation must be given received by the residency office **at least** one month prior to the month of the requested vacation. Failure to meet this prescribed time frame will result in denial of leave.
2. Leave will be processed through New Innovations. You may access this link by going to Schedules>Make a Request>fill in dates> >Choose type of leave>Choose who will receive

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

request (your program Coordinator)>Review>Submit.

3. Completed and approved forms will be received in the Residency/Fellowship Office to be filed with time sheet at the end of each month which is tracked by the GME Office.
4. You will receive a confirmation email from the residency/fellowship office within seven days of submission. Please follow up on request if you do not receive confirmation email. This email must be presented in clinic for continuity clinic cancellation approval.
5. Call assigned to a resident/fellow on the published roster for the month has to be done by the named resident. ***Exchanging call after the published roster is on New Innovations must involve information/approval from both parties and coordination with chief resident.***
6. Hours logged into NI must match leave request and elective attendance cards. If time requested is different from form, you must correct this with the residency/fellowship office.
7. Be sure to observe all of the back-up policies.
8. Continuity Clinic
    - **Annual leave** during continuity clinic block must be requested through New Innovations a minimum 30 days in advance for a one day absence (90 days in advance for absence of more than one day). A clinic cancellation form must be completed, preceptor's signature obtained and submitted to the clinic a minimum of 30 days in advance (90 days in advance for more than one day). Exceptions must be approved by the Program Director.
    - **Administrative Leave** request must be submitted through New Innovation as early as possible. If resident is assigned to continuity clinic, a clinic cancellation form must be completed, signed and submitted to the clinic as soon as possible.
    - **Education leave** during continuity clinic must be requested a minimum of 30 days in advance. A clinic cancellation form must be completed, signed and submitted to the clinic a minimum of 30 days in advance.
    - **Sick Leave** during continuity clinic requires immediate notification to the clinic and a sick leave request submitted through New Innovations. Sick leave of two consecutive days or more requires a doctor's excuse submitted to the Program.

Attendance requirements

For satisfactory completion of training, (necessary for graduation), ALL residents must complete, and pass, all rotations, as scheduled by the Program and in line with the agreed training curriculum unless a waiver of training has been granted. (See GME and Internal Medicine Handbooks). This requires submission of completed overall rotation in-training evaluation reports for every rotation, including elective blocks.

Updated 7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Internal Medicine Residency Event/Committee Attendance and Absence Policy

Purpose:

- Provide detailed information related to program event absences.
- Provide detailed information on attendance expectations required for satisfactory completion of training in the Internal Medicine Residency Program.

Scope: All IM Residents and Attending Physicians

Definitions:
In this policy "Mandatory events" include, but are not limited to:

- Academic Half Day
- Program and Clinic Orientations
- SIM Lab sessions
- Retreats
- Semi-Annual Reviews
- Clinical Conferences
- Core Conferences
- Rotation Assignments

Procedure:

I. Event/Committee

All residents must attend all scheduled mandatory events and activities, unless on an approved period of absence or medical leave. All residents must attend their Semi-Annual Evaluation meetings and their EXIT interview with their Faculty Advisor and any other meetings felt to be necessary and requested by the Program Director, Faculty Adviser or Preceptor.

24 hour notice is expected notification for absence from activity unless emergent circumstances and then as soon as noted.

Resident Members of the Internal Medicine Residency Program are expected to attend all assigned Committee Meetings, unless granted an approved absence by the Program.

II. Attendance confirmation and tracking

All Residents are expected to check-in to track attendance as appropriate to mandatory events. If a Resident has not verified attendance, the resident is regarded as being absent from the event unless the Program has an approved absence notification or request (or resident is post-call).

Proof of attendance is required for subsequent completion of training and graduation.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

III. Consequences of failing to meet attendance requirements

Failure to attend a mandatory event, in full, without an approved absence is regarded as unprofessional. This will be reviewed with the Resident's Program Director and may have additional disciplinary action taken as deemed necessary.

If a resident has failed to meet any of the above requirements, the resident will be expected to meet with his/her Program Director to discuss absences, if necessary, to plan how the Resident will make up the required activity.

This can require extended training time to allow the resident to meet the attendance requirements prior to completion of training and graduation.

Any failure to attend without an approved absence may also result in the loss of the corresponding number of Annual Leave time as well as the potential disciplinary actions described above.

IV. Absence from Program

Approved Reasons for Absence

Circumstances that qualify are:

- Defined by Federal Medical Leave Act
- Sick Leave
- Vacation
- Educational leave
- Administrative days
- Named holidays
- Military Leave

Note: A Resident who is absent from the program for any of the above reasons, is not required to attend any scheduled educational program activities including seminars, conferences, journal clubs, exam preparation sessions or academic half days but may choose to do so.

V. Notification of absence and consequences of failure of notification

Residents will familiarize themselves with the contact information of their Program Administrators/Coordinators, teaching clinics, Preceptors, or senior Residents so that timely notice is given to the appropriate people when absences are necessary or planned.

Contact information for Program Administrators/Coordinators, teaching clinics, Preceptors, or senior Residents can be found in the curriculum of each rotation in New Innovations.

Residents **must** inform their respective clinics which require 30-day ***minimum cancellation*** and

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Preceptors directly as far ahead as possible of any planned/scheduled absences, including mandatory events, courses etc.

All unplanned/last minute absences from a clinic will require immediate notification by the Resident/Preceptor to the Program office as soon as the absence is known.

When a Resident is unable to attend a clinic or rotation at short notice, the Resident must also notify his/her clinic/rotation ***contact by email*** (or ***other communication*** deemed acceptable by Preceptor).

A Resident who fails to provide acceptable and adequate notification of scheduled absence to their clinic contacts will be reported to the Program office by the Resident's Preceptor so that this can be addressed by the Program Director or their designee.

Repeated failure to communicate absences to the clinic, which is regarded as unprofessional behavior, will result in documentation in the Resident's file and the potential for disciplinary action.

7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Internal Medicine Resident Back-Up/Pay-Back Policy

PURPOSE:

QCOM Internal Medicine Residency's primary goal of the residents is to provide uninterrupted and appropriate patient care that adheres to Clinical Education and Experience. However, in the event of illness, family emergencies, or fatigue mitigation a back-up policy and pay-back policy must be implemented. The program recognizes that residents assigned to back-up will not be invoked without good reason. The program reserves the right to require documentation from the resident requesting back-up. The PGY-IV Chief Resident maintains careful records of the back-up system. Residents requesting back-up must call the PGY-IV chief. Only the PGY-IV chief will contact the resident on back-up.

PROCEDURE:

1. The PGY-IV chief resident in consultation with the program director will schedule all back-up coverage duties at the beginning of each academic year.
2. Each resident will be expected to participate in the on call back-up program.
3. All residents assigned to back-up must be available by cell phone (Tiger Connect) and/or pager 24/7 including weekends/holidays when assigned back-up call. Failure to respond to pager or return the call within 1 hour of the PGY-IV chief contacting the back-up resident will result in notification to the Program Director and can result in a formal disciplinary action for unprofessional behavior.
4. The chief residents will keep a running log of who has called requesting back up and will notify the Program Director should excessive use be suspected.
5. Payback is required for back-up call requests except in the case of personal emergency or approved administrative leave. Back up called for any reason requires an approved leave request on file with the Program. (See leave policy for requirements. Program Director has the authority to make exceptions.)
6. PGY IV chief residents are responsible for facilitating and monitoring back up coverage.

7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

PROCESS FOR POLICY DEVELOPMENT AND IMPLENTATION

PROCEDURE:

1. Policies that are generated by an ACGME or ABIM requirement will be reviewed by the Program Director and then presented for approval to the Program Evaluation Committee
2. Policies generated for information and program specific process must be approved by the PD.
3. The PD may include either the Program Evaluation Committee and/or the Education Committee approval as deemed necessary.

Policy Formatting

1. All policies must be formatted in ***Word*** to include a title, purpose statement and/or policy statement, scope of practice and procedure.
2. Handbook policies must be formatted in the same manner.
3. Effective/Review date must also be annotated.

Policy Posting

1. Following approval and formatting, policies are placed on New Innovations via the Administration module.
2. As new policies are posted, the program will alert residents via text page.
3. Residents may access, review and acknowledge receipt of new policies from their login page.

Handbook

1. The Handbook will be updated at least annually to incorporate all IM Residency Policies.
2. The updated handbook will be posted on the Residency Website and in New Innovations under resources.

7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Internal Medicine Residency Master Schedule Lottery Process

PURPOSE:

In order to promote fairness and transparency, the IM Residency Program will conduct a lottery process for the purpose of assigning electives and vacation months during the PGY-II and PGY-III year. Since the ACGME recommends that each resident must rotate through all IM eleven (11) subspecialties, this lottery will be conducted to facilitate additional assignment of subspecialty electives that match the resident's choice of future career paths.

The lottery will include rotations in Cardiology, GI, ID, Medical Oncology and Pulmonary Critical Care. Other rotations such as Ambulatory, Nephrology, Rheumatology, Endocrinology and Emergency Medicine may be included in the lottery if they are available after all requirements are met. Residents will also request their vacation blocks for the next academic year.

POLICY:

This will be an electronic process. Rising PGY-III's will have 1st priority (1st round), rising PGY II's with have 2nd Round. Once the Master Schedule for the next academic year is completed, residents may make an appeal for schedule change directly to the Program Director. The program will reserve the right to make changes so that no resident's graduation requirements are violated.

SCOPE: Residents

PROCEDURE:

1. Residency Office will develop a list of required rotations the residents will need to be assigned in order to meet the ACGME and ABIM requirements for accreditation and board certification respectfully. These documents will be ready in mid-December and will be sent to all residents.
2. Program Administration will determine the number of ward service rotations and required rotations for each resident in each level training.
3. Rising PGY III's will be provided an individualized list of needed requirements in advance of the lottery.
4. The Elective Lottery will occur in late February.

Updated 7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Internal Medicine Residency ACLS Policy

Purpose:

To ensure that all Internal Medicine residents and fellows are trained to provide Advance Cardiac Life Support (ACLS).

Policy:

As a matter of patient safety, all residents and fellows in the Internal Medicine Department are required to have current ACLS certification. This certification is good for 2 years and renewals are eligible for reimbursement from the Education Fund Allotment. Trainees who are due for renewal during a Wellmont facility rotation will need to check with the Community Hospital APD to see if they are eligible to participate in a training class free of charge.

Scope: All Internal Medicine Residents and Fellows

Procedure:

1. The Residency Staff office enters ACLS certification information into New Innovations. Based on the expiration date, New Innovations begins generating notifications 90 days prior to certification expiration.

2. Residents are ACCOUNTABLE for scheduling ACLS recertification based on their Master Schedule and certification expiration dates. Elective months are preferred rotations for scheduling recertification.

3. Recertification should not be scheduled during ward months. Residents are not allowed to schedule certification during assigned shifts on ward months; however, may use their day off.

4. The Education Allotment maybe used to cover the cost of recertification. However, if the trainee allows the certification to expire, they are responsible for the cost of the course to reinstate certification. Additionally, if the trainee registers for a class and does not attend the course, the resident is responsible for the cost of the course.

5. Failure to recertify within 15 days of expiration of certification may result in removal from clinical duties until certification is obtained. If the trainee is on a ward month, they will be required to find a replacement to work their shift and will required to pay back the coverage.

6. Failure to recertify within 15 days of expiration of certification may result in removal from

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

clinical duties until certification is obtained. If the trainee is on a ward month, they will be required to find a replacement to work their shift and will required to pay back the coverage.

7. Failure to recertify within 15 days of expiration of certification may result in removal from clinical duties until certification is obtained. If the trainee is on a ward month, they will be required to find a replacement to work their shift and will required to pay back the coverage.
8. If trainees register after certification expires they will have to take the full course again rather than the renewal course. In addition to the extra time it takes to complete the course, trainees will be assigned leave without pay.

10. It is very important that trainees complete all pre-course requirements.
11. Trainees must bring the recertification card to the residency office for processing in New Innovations.

7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Internal Medicine Residency PGY I Chart Audit Policy

Purpose:

To assist the Clinical Competency Committees evaluation of the PGY 1 residents' milestones, the program will audit three (3) in-patient records each six week block interns are assigned to an in-patient ward service.

Scope: PGY I residents, Chiefs and Program Leadership

Procedure:

The PGY 4 Chiefs and the HVMC PGY3 Lead will conduct a comprehensive chart audit on three in-patient records each six week block the intern is assigned to an in-patient ward service. By the end of the academic year, the resident should have a total of 12 chart audits.

1. The auditor will select three discharged patient assigned to the intern during their 2nd or 3rd week of the rotation. It is very important to have a completed record in order to audit all elements.

2. Using the audit form located on New Innovations, the auditor will review all elements included in the History and Physical, The Progress and the Discharges summary section. There are two sections for progress notes. If the Length of Stay exceeds 3 days, the 2nd progress section can be later in the hospital stay. The Discharge Summary section must be completed; therefore, only completed records are to be selected for the audits. Following completion of the audit, the chief/site director will provide immediate feedback to residents for major non-compliant findings.

3. Program Leadership will assess audit competency of the chief residents by reviewing audit records for accuracy. Competency will be confirmed at the first of each academic year.

4. The completed audit forms will be sent to the residency office. The residency staff will aggregate percentage compliance in each of the three components and an overall percentage score and this will be entered into New Innovations under custom data. This information will be part of the portfolio review for semi-annual evaluations and CCC meetings.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

5. The residency office will send an electronic copy of the completed audit forms to the residents each month. Residents are responsible for reviewing the audits and making plans improving performance.

7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

IM Residency Transition of Care Policy (VI.E.3)*

Purpose:

In the course of patient care, it is often necessary to transfer responsibility for a patient's care from one physician to another. Hand-off refers to the orderly transmittal of information, face-to-face, that takes place when transitions in the care of the patient are occurring. The purpose of this policy is to define a safe process to transfer important information, responsibility and authority from one provider to another.

Hand-off occurs upon admission, at shift changes, before and after procedures, upon unit changes, and at discharge. Hospital hand-offs are high-risk, high-frequency events in which critical information about a patient's clinical status, including current condition and recent and anticipated treatment, must be transferred completely and accurately to ensure safe and effective continuity of care. Proper hand-off should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that occurred during that shift.

Policy:

The IM Residency hand-off is verbal communication which provides information to facilitate continuity of care. Hand-offs must follow a standardized approach and include the opportunity to ask and respond to questions. Use of a hand-off form is allowed, however, hand-offs must occur in person allowing the receiving resident an opportunity to ask questions.

Scope: All IM Residents

Procedure:

The following procedures apply to all physicians who are teachers or learners in a clinical environment and have responsibility for patient care in that environment.

1. Hand-off procedures will be in conjunction with (not be limited to) the following events:
    - Shift changes
    - Changes in on-call status
    - When contacting another physician when there is a change in the patient's condition
    - Transfer of patient from one care setting to another, especially the patient admitted from the Emergency Service to the Teaching Service
    - Move to a new unit
    - Service Change
    - Discharge to another institution or facility

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

2. Verbal handoffs are permitted when contacting another physician for change in patient's condition or with changes in on-call status only. Handoffs will be conducted in a consistent manner, using a standardized hand-off format.

3. Hand-off requires a process for verification of the received information, including repeat-back or read-back as appropriate.

4. The hand-off process must include an opportunity for the on-coming physician to ask pertinent questions and request information from the reporting physician.

5. Each hand-off process must be conducted discreetly and free of interruptions.

6. Each hand-off process must include at a minimum, a senior resident or attending physician.

Responsibilities:

The transferring resident or attending must:
1. Comply with hand-off policy and procedures
2. Resolve discrepancies and concerns in a timely manner
3. Face-to-face handoff is preferable, therefore, residents are encouraged to stay in the hospital to handoff to the senior resident or the attending that is coming onto the service
4. Telephonic hand-off is not recommended and should be used only in rare incidences.

The receiving resident or attending must:
1. Receive verbal hand-off
2. Resolve any questions with the transferring resident or attending prior to acceptance of a patient.

The program director must:
1. Arrange resident schedules and assignments to minimize transitions in care
2. Instruct Chief Residents or Site Directors to review and document on a regular basis a sample of a transition, to include review of a sample patient's chart and interview of the incoming responsible individual and/or team to ensure key elements in the patient care continuum for that patient have been transmitted and are clearly understood.

5/2018

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Internal Medicine Residency Program Consultation Policy

Purpose:

To facilitate the process of securing appropriate, timely, cost effective, and educational consultations from other physicians and ancillary health care providers for the purpose of delivering outstanding care to patients and promoting the educational mission of the ETSU Internal Medicine Residency Program.

Scope:

All ETSU Internal Medicine Residents, Faculty, and Physicians and other Health Care Providers with privileges at Institutions affiliated with the ETSU Internal Medicine Residency Program.

Procedure:

1. All consultations of other Health Care Providers at all institutions affiliated with the ETSU Quillen College of Medicine Internal Medicine Residency Program will be initiated with either a face to face or telephone conversation between the Primary Attending Physician or assigned Senior Resident, and the consulted Health Care Provider. This will be followed, if appropriate, by an officially recorded order consistent with the Affiliated Institution's policies.

2. First Year Internal Medicine Residents will not be permitted to initiate a consultation but may record a consultation order under direct supervision of a senior resident or attending physician.

3. The initial conversation will include the purpose and goals of the consultation, the urgency or non-urgency of the consultation, and may allow the Consulted Health Care Provider to suggest or initiate measures enhancing the delivery of cost effective and outstanding patient care.

4. Senior Residents' performance of this task will be mentored and evaluated by their attending physician as one of the six core competencies required by the ACGME.

5. This policy will be monitored by the Program Director, the Associate Program Directors or Site Director at each Affiliated institution, and our Chief Residents.

1/2014

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Third Year Chief Resident Duties

Each Third Year Chief resident is expected to serve Holston Valley Medical Center or Johnson City Medical Center during the quarter they are assigned to perform this function. The Third Year Chief resident in general is responsible for the day-to-day operation of the resident team, coordinating the educational opportunities for the team and documenting attendance, and organization of the daily rounds.

The Third Year Chief resident is responsible for and expected to:

1. Teach the residents and medical students the art and science of internal medicine and serve as a role model of the six core competencies (Patient care, Medical Knowledge, Interpersonal Communication, Practice-based Learning and Improvement, Professionalism and Systems Based Practice).
2. Communicate schedule issues with the PGY4 Chief Residents.
3. Know and enforce all residency policies available on New Innovations.
4. Enforce the call schedule and help coordinate any issues with Chief Residents.
5. Attend weekly clinic faculty meetings unless post-call to provide data on the weekly review sheet. If post-call, please forward form to Pat Jessee at Holston Valley or Melissa Sells at Johnson City by Wednesday evening.
6. Facilitate and enforce the on-call and service backup policies.
7. Obtain written documentation via email if any resident requests leave or a backup resident for their call. An email should be sent to the Program Administrator with cc email to the Program Director.
8. Attend Academic Half Day on Tuesday morning (unless post call).
9. Assist in the management of the facility based education curriculum and weekly lectures.
10. Be knowledgeable in the science of quality improvement and patient safety initiative.
11. Facilitate integration of residents into the quality and patient safety initiative.
12. Assign education topics to each resident (1 per month) as well as a student lecture and students (1 per week) to present in the form of 3-5 PowerPoint slides and to last no more than 7-10 minutes. The schedule should be posted in the room and forwarded to the APD by the end of the first week of each month.
13. Intern should present an extended morning report on one of the patients admitted the previous day or previous week at HVMC or any interesting patient from previous month. If intern cannot find a case, a case report should be discussed from Mayo/Cleveland/NEJM or any academic journal.
14. Be familiar with the ACGME resident requirements, specifically Clinical Education and Experience guidelines, and make every effort to adhere to them. Clinical Education and

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Experience should be reported accurately and any violation should be addressed immediately with the help of the PGY4 Chief Resident or APD.

15. Assist in conflict resolution between resident and when practical, talk to the PGY4 Chief Resident first. If not resolved, then discuss with APD.
16. Direct night intern to write progress notes on ICU patients after 8:00 pm.
17. Assist in face-to-face afternoon sign out with attending.
18. Ensure team always admits to attending on service but mention attending on call discussed with in History and Physical. Switch admission to next week at 4:30 pm on Sundays.
19. Ensure CQI project information is completed. Checklist for post-discharge phone calls on admission sheet (copies to faculty). “Mug shots” given to new admissions.
20. Pick two random patients identified by start of 2nd week of rotation for chart audit for each intern. Include information on weekly review sheet to faculty.
21. Assign and/or complete weekend/holiday patient assignments.
22. Obtain feedback on each intern’s performance from senior medical resident and address any areas of concern with the help of attending at a minimum of three times per month. Use feedback form.
23. Ensure that all residents and interns have CSMD access and remind them to check on patients admitted on controlled substances.
24. Keep a log sheet of all admissions and consults (patient name and diagnosis, attending physicians, PGY-1 etc.)
25. Monthly orientation of residents as well as student orientation on the first day of each rotation.

5/2018

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

USMLE STEP 3 POLICY

Purpose: The purpose of this policy is to outline the Program's expectations and consequences of taking USMLE Step 3.

Policy: All PGY1s will take USMLE Step 3 exam by December 31 of PGY1 year, and pass USMLE Step 3 exam by June 30 of PGY1 year.

Scope: PGY 1

Procedure: All PGY1s should schedule to take USMLE Step 3 exam before December 31 and submit the official transcript to the Program as soon as the resident receives the score.

Should a resident not take the exam before December 31 of PGY1 year as required, the resident will be placed on probation, reviewed by the Clinical Competency Committee (CCC) and could be subject to further disciplinary action. Should a resident not pass Step 3 by June 30 of PGY1 year, then the resident will be reviewed by the CCC, the resident will not be advanced to PGY2 status at the end of the PGY1 year, and will be subject to disciplinary action up to and including termination of residency at the end of PGY1 year.

7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Quality Improvement Project/Patient Safety Event
(VI.A.)*

Purpose: As part of the Systems-Based Learning Milestone and to meet graduation requirements residents will complete a Quality Improvement (QI) or Patient Safety (PS) project.

Scope: All Internal Medicine Residents

Policy: Residents must have the opportunity to participate in interprofessional quality improvement activities. **(VI.A.1.b).(3)** Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. **(VI.A.1.a).(3).(b)***

Definitions:

Scholarly Activity: Teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety.

Quality Improvement: A systems-based change to improve patient care.

Patient Safety: Investigating, reporting and following-up of adverse events, near misses and unsafe conditions regarding patients.

Procedure: A resident must first complete the Department Approval for Quality Improvement Project form and obtain clinic preceptor's signature for approval for any Quality Improvement or Patient Safety Project. The form will then be submitted to the Program Director (PD) for review and approval. The PD may make changes and/or suggestions to the proposed project. Once the PD signs the form, the Coordinator will then enter the information for tracking the progress of the project. The progress will then be reviewed and approved by the Program Evaluation Committee. The resident's project progress will be reviewed at every Semi-Annual Review meeting for progress status and reported back to the Program. Once completed, the resident will present the project at Academic Half Day and upload a copy of the finished project into New Innovations.

7/2019

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

GLOSSARY OF TERMS

May 8, 2018

Current as of May 2018

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

ACGME GLOSSARY OF TERMS

Accreditation Data System (ADS): A web-based software system to collect, organize, and maintain information for accreditation and recognition purposes, and a means of communication between the ACGME and Sponsoring Institutions and programs.

Accreditation status: The official decision made by a Review Committee based on its review and assessment of a Sponsoring Institution's or program's compliance with the applicable requirements. *See Appendix I for more information.*

Advancing Innovation in Residency Education (AIRE): A pilot program with the dual aims of 1) enabling the exploration of novel approaches and pathways in graduate medical education, and 2) enhancing the attainment of educational and clinical outcomes through innovative structure and processes in resident and fellowship education.

Adverse action: A Review or Recognition Committee's decision to confer an adverse accreditation or recognition status on a Sponsoring Institution or program (i.e., Accreditation Withheld, Probationary Accreditation, Withdrawal of Accreditation, Withdrawal of Accreditation Under Special Circumstances, and non-voluntary Reduction in Resident Complement).

Adverse event: An injury that was caused by medical management (rather than the underlying disease), and that prolonged hospitalization, produced a disability at the time of discharge, or both.

Alleged egregious event: The occurrence of an alleged accreditation violation affecting a Sponsoring Institution or program determined by the President and Chief Executive Officer of the ACGME to be of sufficient importance and urgency to require a rapid response.

Applicant: An individual invited to interview with a graduate medical education program.

At-home call (pager call): Call taken from outside the assigned site. Clinical work done while on at-home call, including time spent in the hospital and work done at home, such as taking calls or entering notes in an electronic health record (EHR), counts against the 80-hour-per- week limit but does not restart the clock for time off between scheduled in-house clinical and educational work periods. The remaining time, free of clinical work, does not count. At-home call may not be scheduled on a resident's or fellow's one free day per week (averaged over four weeks).

Attending physician: The single identifiable physician ultimately responsible and accountable for an individual patient's care, who may or may not be responsible for supervising residents or fellows.

Categorical resident: A resident who enters a program and has the objective of completing the entire program.

Certification: The official attestation by a specialty certifying board of an individual physician's knowledge and skills relative to the provision of high-quality care in a particular specialty, generally following successful completion of one or more examinations. The ACGME does not provide certification services.

Citation: A finding of a Review or Recognition Committee that a Sponsoring Institution or program has failed to comply substantially with a particular accreditation or recognition requirement.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Clarifying information: Additional information that may be requested by a Review or Recognition Committee as part of the review process.

Clinical: The practice of medicine in which physicians assess patients (in person or virtually) or populations in order to diagnose, treat, and/or prevent disease using their expert judgment. It also refers to physicians who contribute to the care of patients by providing decision support and information systems, laboratory, imaging, or related studies.

Clinical Competency Committee (CCC): A required body comprising three or more members of the active teaching faculty that is advisory to the program director and reviews the progress of all residents or fellows in the program.

Clinical Learning Environment Review (CLER) Program: An ACGME program designed to provide US teaching hospitals, medical centers, health systems, and other clinical settings affiliated with ACGME-accredited Sponsoring Institutions with periodic feedback in Focus Areas specific to the safety of the clinical learning environment.

CLER Site Visit: A visit conducted by CLER Field Representatives that includes interviews with faculty members, program directors, residents and/or fellows, participating site personnel, institutional leadership, and other selected staff members, and the review of institutional documentation, as needed, to assess the effectiveness of the Sponsoring Institution and its participating sites in managing the integration of GME in the six CLER Focus Areas.

Common Program Requirements: The ACGME requirements that apply to all specialties and subspecialties with the exception of those subspecialties that have adopted the One-Year Common Program Requirements. These requirements are denoted by bold text within the specialty- and subspecialty-specific Program Requirement documents. *Definition will be reviewed for an update pending approval of the revised Common Program Requirements*

Competencies: Specific knowledge, skills, behaviors, and attitudes in the following domains: patient care and procedural skills; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice.

Complaint: An allegation that a Sponsoring Institution or program is non-compliant with accreditation or recognition requirements.

Complement: The maximum number of residents or fellows approved by a Review Committee per year and/or per program based upon availability of adequate resources.

Conditional independence: Graded, progressive responsibility for patient care with defined oversight.

Consortium: An association of two or more organizations, hospitals, or institutions that have come together to pursue common objectives (e.g., graduate medical education).

Designated institutional official (DIO): The individual in a Sponsoring Institution who has the authority and responsibility for all of that institution's ACGME-accredited programs.

Didactic: Systematic instruction by means of planned learning experiences. See the applicable ACGME Program Requirements for more information.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Clinical and educational work hours: All clinical and academic activities related to the program: patient care (inpatient and outpatient); administrative duties relative to patient care; the provision for transfer of patient care; time spent on in-house call; time spent on clinical work done from home; and other scheduled activities, such as conferences. These hours do *not* include reading, studying, research done from home, and preparation for future cases.

Extraordinary circumstance: A situation or event that significantly alters the ability of a Sponsoring Institution and its programs to support resident/fellow education. *For more information, see ACGME Policies and Procedures Subject 21.00*.

Faculty: The group of individuals (both physician and non-physician) assigned to teach and supervise residents/fellows.

> **Core faculty:** All physician faculty members in a specialty program who have a significant role in the education of resident/fellows and who have documented qualifications to instruct and supervise. Core faculty members devote at least 15 hours per week to resident education and administration. All core faculty members should evaluate the competency domains; work closely with and support the program director; assist in developing and implementing evaluation systems; and teach and advise residents. *Definition will be reviewed for an update pending approval of the revised Common Program Requirements*

Fatigue mitigation: Methods and strategies for learning to recognize and manage fatigue to support physician/caregiver well-being and safe patient care (e.g., strategic napping; judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods).

Fellow: An individual enrolled in an ACGME-accredited fellowship (subspecialty) program who has completed a residency program in a related specialty. Note: the term may also refer to other learners by individual institutions or programs.

Fellowship: A program that provides advanced training in progressive levels of sub- specialization following completion of training in a primary specialty and, if applicable, a related sub-subspecialty. It is a structured educational activity comprising a series of clinical and/or other learning experiences designed to train physicians to enter the unsupervised practice of medicine in a subspecialty. (See also Subspecialty program and Sub-subspecialty program)

> **Residency-dependent subspecialty program:** A program required to function with an accredited residency program in its related specialty. The Continued Accreditation of the subspecialty program is dependent on the residency program's maintaining its accreditation. A residency-dependent subspecialty program must be sponsored by the same ACGME-accredited Sponsoring Institution as the associated residency program.
>
> **Residency-independent subspecialty program:** A fellowship program that is not required to function with an accredited residency program in its related specialty. These subspecialty programs are dependent on an ACGME-accredited Sponsoring Institution. These programs may occur in two circumstances:
>
> > 1. The program is reliant upon an ACGME-accredited Sponsoring Institution that sponsors programs in more than one specialty and/or subspecialties.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

2. The program is reliant upon an ACGME-accredited Sponsoring Institution that sponsors a program or programs in only one subspecialty.

Sub-subspecialty program: A program that provides advanced training in progressive levels of specialization following completion of training in both the primary specialty and its related subspecialty. It is a structured educational activity comprising a series of clinical and/or other learning experiences designed to train physicians to enter the unsupervised practice of medicine in a sub-subspecialty. Each sub-subspecialty program must be dependent on a related subspecialty program sponsored by the same ACGME-accredited Sponsoring Institution.

Fitness for work: The condition of being mentally and physically able to effectively perform required clinical responsibilities and promote patient safety (see Fatigue mitigation).

Formative Evaluation: Assessment of a resident/fellow with the primary purpose of providing feedback for improvement, and for reinforcement of skills and behaviors that meet established criteria and standards without passing a judgment in the form of a permanently recorded grade or score. *Definition will be reviewed for an update pending approval of the revised Common Program Requirements*

Graduate medical education: The period of didactic and clinical education in a medical specialty or subspecialty which follows the completion of undergraduate medical education and which prepares physicians for the independent practice of medicine in that specialty or subspecialty. Also referred to as residency or fellowship education.

In-house call: Clinical and educational work hours, beyond the scheduled workday, when residents are required to be immediately available within an assigned site, as needed, for clinical responsibilities. In-house call does not include night float, being on call from home, or regularly scheduled overnight duties.

Institutional review: The process of determining whether a Sponsoring Institution offering graduate medical education programs is in substantial compliance with the Institutional Requirements.

International medical graduate (IMG): A graduate from a medical school outside the United States and Canada. IMGs may be citizens of the United States who chose to be educated elsewhere or non-citizens who are admitted to the United States by US Immigration authorities.

Interprofessional team: The physicians and other health care professionals, including nurses, pharmacists, case workers, physical therapists, etc., as appropriate, assigned to the delivery of care for an individual patient.

In-training examination: A formative examination used to evaluate resident/fellow progress in meeting the educational objectives of a residency/fellowship program, including but not limited to those offered by certification boards or specialty societies.

Letter of Notification: The official communication from a Review or Recognition Committee that states an action taken by the committee.

Milestones: Description of performance levels residents and fellows are expected to demonstrate for skills, knowledge, and behaviors in the six ACGME Core Competency domains.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Moonlighting: Voluntary, compensated, medically-related work performed beyond a resident's or fellow's clinical experience and education hours and additional to the work required for successful completion of the program.

> **External moonlighting:** Voluntary, compensated, medically-related work performed outside the site where the resident or fellow is in training and any of its related participating sites.
>
> **Internal moonlighting:** Voluntary, compensated, medically-related work performed within the site where the resident or fellow is in training or at any of its related participating sites.

Multidisciplinary Subspecialty Program: a subspecialty is that is co-sponsored by multiple specialties and is accredited by multiple Residency Review Committees.

Must: A term used to identify a requirement which is mandatory or done without fail when the requirement is categorized as "Core" or "Outcome", and in each of the following additional circumstances regardless of the categorization assigned to the requirement:

> For accreditation purposes: (1) a Sponsoring Institution or program is applying for accreditation, or (2) a program or Sponsoring Institution holds a status of Initial Accreditation, Initial Accreditation with Warning, Continued Accreditation without Outcomes, Continued Accreditation with Warning, or Probationary Accreditation
>
> For recognition purposes: (1) a Sponsoring Institution or program is applying for recognition, (2) a program or Sponsoring Institution holds a status of Initial Recognition, Initial Recognition with Warning, Continued Recognition without Outcomes, Continued Recognition with Warning, or Probationary Recognition

When a "must" requirement is categorized as "Detail," a program holding a status of Continued Accreditation or Continued Recognition may utilize alternative or innovative approaches in meeting the associated "Core" requirement(s), where applicable.

Near miss: An event or situation that did not produce patient injury, but only because of chance.

Night float: A rotation or other structured educational experience designed either to eliminate in-house call or to assist other residents/fellows during the night. Residents/fellows assigned to night float are assigned on-site duty during evening/night shifts, are responsible for admitting or cross-covering patients until morning, and do not have daytime assignments. Such a rotation must have an educational focus.

One day off: One continuous 24-hour period free from all administrative, clinical, and educational activities. *For more information, see the Common Program Requirement FAQs.*

Osteopathic Principles Committee: A Recognition Committee with delegated authority from the ACGME Board to set the Osteopathic Recognition Requirements, provide peer evaluation of programs offering education in Osteopathic Principles and Practice, and make a determination regarding compliance.

Osteopathic Recognition: A determination of substantial compliance with the published Osteopathic Recognition Requirements, following a process of evaluation and peer review.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Participating site: An organization providing educational experiences or educational assignments/rotations for residents/fellows. Examples of participating sites include: a university; a medical school; a teaching hospital, including its ambulatory clinics and related facilities; a private medical practice or group practice; a nursing home; a school of public health; a health department; a federally qualified health center; a public health agency; an organized health care delivery system; a health maintenance organization (HMO); a medical examiner's office; a consortium; or an educational foundation.

Patient safety event: An adverse event, near miss, or other event resulting from unsafe conditions in the clinical care setting.

Pipeline specialties: Specialties that lead to primary board certification. The net output of physicians over time from the graduate medical education system into clinical practice is determined by the number of positions available in pipeline specialties.

Post-Doctoral Program in a Medical or Medical-Related Field: A structured educational activity comprising a series of clinical and/or other learning experiences, designed to train MDs, DOs, and others in a medical or medical-related field. *For more information, see ACGME Policies and Procedures Subject 12.10.*

Post-graduate year (PGY): The denotation of a post-graduate resident's or fellow's progress in his or her residency and/or fellowship training; used to stratify responsibility in most programs. The PGY does not necessarily correspond to the resident's or fellow's year in an individual program. For example, a fellow who has completed a pediatric residency program and is in the first year of a pediatric endocrinology fellowship program is a pediatric endocrinology 1 level and a PGY-4.

Primary clinical site: The primary facility designated for clinical instruction in the program. If the Sponsoring Institution is a hospital, it is by definition the primary clinical site for the residency/fellowship program. If the Sponsoring Institution is a medical school, university, or consortium, the primary clinical site is the site that is used most commonly in the residency/fellowship program.

Program director: The individual designated with authority and accountability for the operation of a residency/fellowship program.

Program evaluation: Systematic collection and analysis of information related to the design, implementation, and outcomes of a graduate medical education program for the purpose of monitoring and improving the quality and effectiveness of the program.

Progress report: A report requested of a Sponsoring Institution or program regarding concerns the Review or Recognition Committee had during its regular review of the institution or program. The progress report must be reviewed by the Sponsoring Institution's Graduate Medical Education Committee (GMEC), and must be signed by the designated institutional official (DIO) prior to submission to the Review or Recognition Committee.

Program Letter of Agreement (PLA): A written document that addresses graduate medical education responsibilities between an individual accredited program and a site other than the Sponsoring Institution at which residents or fellows have required educational experiences.

Program year: Refers to the current year of education (of an individual resident or fellow) within a specific program; this designation may or may not correspond to the resident's or fellow's post-graduate year.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Recognition Committee: See Osteopathic Principles Committee

Recognition status: The official decision made by a Recognition Committee based on its review and assessment of a Sponsoring Institution's or program's compliance with the applicable Recognition Requirements. *See Appendix I for more information.*

Requirements (Institutional and Program):

> **Core Requirements:** Statements that define structure, resource, and process elements essential to every graduate medical educational program.
>
> **Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and Sponsoring Institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to comply with Core Requirements.
>
> **Outcome Requirements:** Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at stages of their graduate medical education.

Resident: An individual enrolled in an ACGME-accredited residency program.

Residency program: A structured educational activity comprising a series of clinical and/or other learning experiences in graduate medical education, designed to prepare physicians to enter the unsupervised practice of medicine in a primary specialty. There are two types of residency programs: (a) residency programs available for physician admission immediately upon graduation from medical school as described in the Institutional Requirements; and (b) residency programs available for physician admission after completion of prerequisite clinical training as described in the relevant specialty-specific Program Requirements.

Review Committee: A group comprised of volunteers that sets accreditation standards (requirements), provides peer evaluation of Sponsoring Institutions or programs to assess the degree to which these comply with the applicable published accreditation requirements, and confers an accreditation status on each Sponsoring Institution or program with regard to substantial compliance with those requirements. There are three types of Review Committee: specialty Review Committee, Transitional Year Review Committee, and Institutional Review Committee.

Site visit (accreditation/recognition):

> **Focused site visit:** A site visit that assesses selected aspects of a Sponsoring Institution or program identified by a Review or Recognition Committee.
>
> **Full site visit:** A full site visit addresses and assesses compliance with all applicable requirements and encompasses all aspects of a Sponsoring Institution or program.
>
> > **10-Year Accreditation Site Visit**: A full site visit occurring every 10 years for each accredited Sponsoring Institution and program and preceded by a comprehensive Self-Study process that includes developing a description of how the Sponsoring Institution or program creates an effective learning and working environment, and how this leads to desired educational outcomes.

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Unannounced site visit: A site visit that is unannounced due to the urgency of an issue(s) that needs immediate review. A Sponsoring Institution or program may receive up to three weeks' notice of unannounced site visits.

Self-Study: An objective, comprehensive evaluation of a residency or fellowship program, with the aim of improving it, conducted ahead of the 10-Year Accreditation Site Visit. Underlying the Self-Study is a longitudinal evaluation of the program and its learning environment, facilitated through sequential annual program evaluations that focus on the required components, with an emphasis on program strengths and "self-identified" areas for improvement.

Scholarly activity: Participation of residents/fellows and faculty members in research, organized clinical discussions, rounds, journal clubs, and/or conferences. Some members of a program's faculty should also demonstrate scholarly activity through one or more of the following: peer-reviewed funding; publication of original research or review articles in peer- reviewed journals or chapters in textbooks; publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or participation in national committees or educational organizations. *For more information, see the Common Program Requirements. Definition will be reviewed for an update pending approval of the revised Common Program Requirements.*

Should: A term used to designate requirements so important that non-substantial compliance must be justified. A Sponsoring Institution or program may be cited for failing to comply substantially with a requirement that includes the term "should" when the requirement is categorized as "Core," and in the following additional circumstances:

For accreditation purposes: (1) a Sponsoring Institution or program is applying for accreditation, or (2) a Sponsoring Institution or program holds a status of Initial Accreditation, Initial Accreditation with Warning, Continued Accreditation without Outcomes, Continued Accreditation with Warning, or Probationary Accreditation

For recognition purposes: (1) a Sponsoring Institution or program is applying for recognition, or (2) a Sponsoring Institution or program holds a status of Initial Recognition, Initial Recognition with Warning, Continued Recognition without Outcomes, Continued Recognition with Warning, or Probationary Recognition.

When a "should" requirement is categorized as "Detail," a program holding a status of Continued Accreditation or Continued Recognition, may utilize alternative or innovative approaches in complying substantially with the associated Core requirement(s), where applicable.

Specialty program: See Residency program

Sponsoring Institution: The organization (or entity) that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements. The Sponsoring Institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, a consortium, or an educational foundation).

Clarification: When the Sponsoring Institution is not a rotation site for the program, the major associated hospital for the program is the primary clinical site (see Primary clinical site).

Subspecialty program (fellowship): See Fellowship program

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.

Summative evaluation: Assessment with the primary purpose of establishing whether performance measured at a single defined point in time meets established performance standards, permanently recorded in the form of a grade or score. *Definition will be reviewed for an update pending approval of the revised Common Program Requirements*

Transfer resident: Residents are considered "transfer residents" under several conditions, including: moving from one program to another within the same or between different Sponsoring Institution(s) and within the same or a different specialty; when entering a program requiring a preliminary year at the PGY-2 level even if the resident was simultaneously accepted into the preliminary PGY-1 program and the PGY-2 program as part of the Match (e.g., accepted to both programs right out of medical school).

The term does not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

Transitional year program: A one-year educational experience in graduate medical education (GME), which is structured to provide a program of multiple clinical disciplines designed to facilitate the choice of and/or preparation for a specialty. The transitional year is a prerequisite; it does not comprise a complete program in GME.

Transitions in care: The relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the health care setting.

Work compression: An increase in the amount of work to be completed without a corresponding increase in the amount of time provided to complete that work.

AST-KM 7/30/2007 TSW
4/21/2008 TSW 8/7/2008
TSW 9/24/08
TSW 01/20/09 TSW
03/2009 TSW 09/18/2009
TSW 09/29/2010 TSW
11/30/2010 TSW
6/28/2011 TSW 7/1/2013
TSW 8/2016 LNJ 4/2017
Glossary Grp 5/2018

*Direct reference from the ACGME Program Requirements for Graduate Medical Education in Internal Medicine.