

Internal Medicine

**PROGRAM HANDBOOK AND
POLICY MANUAL**

2022-2023

University of Colorado School of Medicine
Internal Medicine

Program Personnel and Contact Information

Geoffrey Connors, M.D.

Associate Professor of Medicine
Residency Program Director
Department of Medicine
Phone: 303-724-1788
Fax: 303-724-1799
Email: Geoffrey.Connors@cuanschutz.edu

Jennifer Weber

Residency Program Administrator
Phone: 303-724-1788
Fax: 303-724-1799
Email: Jennifer.Weber@cuanschutz.edu

Program Administration and Leadership

<u>Administrative Staff</u>	<u>Role</u>	<u>Phone</u>
Nicole Canterbury Nicole.Canterbury@cuanschutz.edu	Assistant Program Admin Schedules & Program Requirements	303-724-0957
Elle Contreras Elle.Contreras@cuanschutz.edu	Recruitment and Onboarding Coordinator	303-724-1792
Akemi Iwanabe Akemi.Iwanabe@cuanschutz.edu	Program Administrator Medicine-Pediatrics	303-724-6595
Mary Meadows Mary.Meadows@cuanschutz.edu	Front Desk Reception and Compliance	303-724-1784 (main number)
Erica Mendoza Erica.Mendoza@dhha.org	Primary Care Track Coordinator	303-602-0494
Ava Russell Ava.Russell@cuanschutz.edu	Vice Chair/IMRP Administrator	303-724-1797
Jefferson Velasco Jefferson.Velasco@cuanschutz.edu	Evaluation and Curriculum	303-724-1791
Jennifer Weber Jennifer.Weber@cuanschutz.edu	Program Administrator	303-724-1788

<u>Faculty</u>	<u>Role</u>	<u>Phone</u>	<u>Pager</u>
Joseph Burke, MD Joseph.Burke@dhha.org	Associate Program Director	303-602-4027	303-234-2957
Geoffrey Connors, M.D. Geoffrey.Connors@cuanschutz.edu	Program Director	303-724-1787	303-266-4441
Sarah (Lindsey) Davis, M.D. Sarah.Davis@cuanschutz.edu	Assistant Program Director	303-724-8681	
Lisa Davis, M.D. Lisa.Davis@cuanschutz.edu	Associate Program Director	720-273-2220 (c)	303-234-6179
Amira Del Pino-Jones, M.D. Amira.delpino-jones@cuanschutz.edu	Assistant Program Director for Diversity and Inclusion	720-848-4289	303-266-2106
Emily Gottenborg, M.D. Emily.Gottenborg@cuanschutz.edu	Assistant Program Director Co-Director, Hospitalist Track	610-608-8303 (c)	303-266-2657
Christine Haynes, M.D. Christine.Haynes@dhha.org	Assistant Program Director Primary Care	303-436-4209	303-201-0287
Daniel Heppe, M.D. Daniel.Heppe@va.gov	Associate Program Director	720-771-0667(c)	303-201-0385
Julia Limes, M.D. Julia.Limes@cuanschutz.edu	Associate Program Director Co-Director, Hospitalist Track	720-848-4289 720-470-3306 (c)	303-266-3914

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Adrienne Mann, M.D. Adrienne.Mann@cuanschutz.edu	Associate Program Director	303-594-6168 (c)	
Yasmin Sacro, M.D. Yasmin.Sacro@dhha.org	Associate Program Director, Program Director, Primary Care	303-602-5446	303-266-0381
David Schwartz, M.D. David.Schwartz@cuanschutz.edu	Program Director, PSTP	303-724-1780	919-824-9458 (c)
Kathleen Suddarth, M.D. Kathleen.Suddarth@cuanschutz.edu	Associate Program Director	720-848-2382	303-266-0100

Faculty Listing and Clinical/Research Interests

Faculty Clinical and Research Interests:

Burke – Clinical interests: General cardiology, interventional cardiology, complex coronary interventions, CTO intervention, peripheral vascular disease. Research interests: Medical education, curriculum development, out of hospital cardiac arrest, critical limb ischemia, and percutaneous intervention.

Connors – Clinical interests: ICU care, interstitial lung disease. Research interests: Medical education, clinical reasoning.

Davis, Lindsey – Clinical Interests: GI Oncology. Research Interests: Cancer Clinical Trials with focus on developmental therapeutics and immune-targeted agents; immune related adverse events associated with immune checkpoint inhibitor and other immune targeted cancer therapies

Davis, Lisa – Clinical interests: General Rheumatology. Research interests: Health services research and adverse drug events in rheumatology using observational data.

Del Pino-Jones – Clinical Interests: Hospital Medicine, Medical Student and Resident Education, Mentoring and Advising. Research Interests: Diversity and Inclusion in the Health Professions, Gender Equity in Medicine, Care for Underserved Patient Populations

Gottenborg – Clinical Interests: Hospital Medicine, High Value Care Delivery, Resident Education, Procedure Education. Research Interests: Medical Leadership, Healthcare System Improvement and Redesign, Gender Equity in Medicine

Haynes – Clinical interests: General primary care, women’s health, care of underserved patient populations. Research interests: Advance care planning, population health, sexually transmitted infections.

Heppe – Clinical interests: bedside teaching and evidence based Medicine. Research interests: ETOH withdrawal, substance abuse, transitions of care.

Limes – Clinical interests: Clinical reasoning, inpatient oncology, hospital medicine. Research interests: Content and design of resident education, transitions of care.

Mann – Clinical interests: Bedside teaching, transitions of care. Research interests: ECG teaching, curricular development, Resident Wellness

Sacro – Clinical interests: General primary care, care of vulnerable populations, medical education, diversity, equity, and inclusion.

Schwartz – Research interests: Genetics and genomics of pulmonary fibrosis, gene discovery in innate immunity and epigenetics of environmental lung disease.

Suddarth - Clinical interest: General primary care. Research interests: Innovations in resident education and new models for resident evaluation.

Program Aims

- We aim to cultivate the next generation of expert clinicians – leaders who will provide outstanding patient care while transforming healthcare through biomedical discovery, educational innovation, optimization of health systems, and advocacy on behalf of those we serve.
- We aim to provide residents an individualized training experience which will allow them to focus on their particular career aspirations in order to best prepare them for their future careers.
- We aim to provide a diversity of clinical training environments in terms of patient populations, healthcare systems and clinical experiences.
- We aim to provide a robust clinical training experience that will adequately prepare any resident for any future challenges.
- We aim to instill in our residents the qualities of a physician that we most value: empathy, inquiry, dedication, responsibility and professionalism in order to best prepare them to care for the communities they will serve.
- We aim to create a learning environment that values inclusion and diversity.

Program Curriculum

Overall Educational Program Goals

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

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

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

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Patient Care and Procedural Skills

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

Residents are expected to demonstrate the ability to manage patients:

- 1).(a) in a variety of roles within a health system with progressive responsibility to include serving as the direct provider, the leader or member of a multi-disciplinary team of providers, a consultant to other physicians, and a teacher to the patient and other physicians; (Outcome)
- 1).(b) in the prevention, counseling, detection, and diagnosis and treatment of gender-specific diseases; (Outcome)
- 1).(c) in a variety of health care settings to include the inpatient ward, the critical care units, the emergency setting and the ambulatory setting; (Outcome)
- 1).(d) across the spectrum of clinical disorders seen in the practice of general internal medicine including the subspecialties of internal medicine and non-internal medicine specialties in both inpatient and ambulatory settings; (Outcome)
- 1).(e) using clinical skills of interviewing and physical examination; and, (Outcome)
- 1).(f) by caring for a sufficient number of undifferentiated acutely and severely ill patients. (Outcome)
- 2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (Outcome)
 - 2).(a) are expected to demonstrate the ability to manage patients:
 - 2).(a).(i) using the laboratory and imaging techniques appropriately; and, (Outcome)
 - 2).(a).(ii) by demonstrating competence in the performance of procedures mandated by the ABIM. (Outcome)
 - 2).(b) must treat their patient's conditions with practices that are safe, scientifically based, effective, efficient, timely, and cost effective. (Outcome)

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Residents are expected to demonstrate a level of expertise in the knowledge of those areas appropriate for an internal medicine specialist, specifically:

- 1).(a) knowledge of the broad spectrum of clinical disorders seen in the practice of general internal medicine; and, (Outcome)
- 1).(b) knowledge of the core content of general internal medicine which includes the internal medicine subspecialties, non-internal medicine specialties, and relevant non-clinical topics at a level sufficient to practice internal medicine. (Outcome)
- 2) are expected to demonstrate sufficient knowledge to
 - 2).(a) evaluate patients with an undiagnosed and undifferentiated presentation; (Outcome)
 - 2).(b) treat medical conditions commonly managed by internists; (Outcome)
 - 2).(c) provide basic preventive care; (Outcome)
 - 2).(d) interpret basic clinical tests and images; (Outcome)
 - 2).(e) recognize and provide initial management of emergency medical problems; (Outcome)
 - 2).(f) use common pharmacotherapy; and, (Outcome)
 - 2).(g) appropriately use and perform diagnostic and therapeutic procedures. (Outcome)

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Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self- evaluation and life-long learning. (Outcome)

Residents are expected to develop skills and habits to be able to meet the following goals:

- 1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)
- 2) set learning and improvement goals; (Outcome)
- 3) identify and perform appropriate learning activities; (Outcome)
- 4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)
- 5) incorporate formative evaluation feedback into daily practice; (Outcome)
- 6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; (Outcome)
- 7) use information technology to optimize learning; and, (Outcome)
- 8) participate in the education of patients, families, students, residents and other health professionals. (Outcome)

Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Residents are expected to:

- 1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)
- 2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)
- 3) work effectively as a member or leader of a health care team or other professional group; (Outcome)
- 4) act in a consultative role to other physicians and health professionals; and, (Outcome)
- 5) maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

- 1) compassion, integrity, and respect for others; (Outcome)
- 2) responsiveness to patient needs that supersedes self-interest; (Outcome)
- 3) respect for patient privacy and autonomy; (Outcome)
- 4) accountability to patients, society and the profession; and, (Outcome)
- 5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)

Residents are expected to:

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- 1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)
- 2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)
- 3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population- based care as appropriate; (Outcome)
- 4) advocate for quality patient care and optimal patient care systems; (Outcome)
- 5) work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)
- 6) participate in identifying system errors and implementing potential systems solutions. (Outcome)
- 7) work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients including the transition of care between settings; and, (Outcome)
- 8) recognize and function effectively in high-quality care systems.

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

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

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

ACGME CORE COMPETENCIES- Expectations for performance by PGY level

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

PGY1:

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

PGY 2 and 3:

- 1) Fulfillment of all the expectations of a PGY 1 as listed above
- 2) Formulation of independent diagnostic and therapeutic plans with the supervision of supervising attending physician

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- 3) Coordination of patient care among all members of the health care team
 - 4) Counseling and education of patients and their families
 - 5) Development of competence in performing the core procedural skills essential to the practice of medicine
- **MEDICAL KNOWLEDGE:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and social-behavioral sciences, and the application of this knowledge to patient care

PGY I:

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

PGY 2 and 3:

- 1) Fulfillment of all the requirements for PGY 1
 - 2) Development of deeper understanding of disease states and their management
 - 3) Development of skills in the reading and interpretation of the medical literature with application to patient care
- **PRACTICE-BASED LEARNING AND IMPROVEMENT:** Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

PGY 1:

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

PGY 2 and 3:

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- 1) Fulfillment of all the requirements for PGY 1
 - 2) Application of knowledge of study designs and statistical methods to the appraisal of clinical studies
 - a. These skills are emphasized in OBMT rotations, journal club, ambulatory clinics
 - 3) Development of competence in bedside teaching
 - 4) Facilitate learning of students, junior residents and other health care professionals
 - 5) Participation in monthly journal club
- **INTERPERSONAL AND COMMUNICATION SKILLS:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, families and professional associates.

PGY 1,2 and 3:

- 1) Development of strong language and documentation skills
 - a. Succinct and comprehensive case presentations and progress notes
 - b. Comprehensive computer-based sign out of patient care issues
 - 2) Efficient but comprehensive information exchange with colleagues, health care professionals, patients and their families
 - 3) Development of effective listening skills
 - 4) Establishment of a therapeutic and ethically sound relationship with patients and their families
 - 5) Development of effective negotiation and leadership skills that assist in conflict avoidance, resolution (PGY 2 and 3 level)
- **PROFESSIONALISM:** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

PGY 1,2 and 3:

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

- **SYSTEMS-BASED PRACTICE**

PGY 1.2 and 3: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, and the ability to effectively call on system resources to provide care that is of optimal value.

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

- **Didactics and Conferences**

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

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

Wednesday Education conference material is available within MedHub under the conference tab.

- **Research and Scholarly Activities/Requirements**

Required for R1s, R2s and R3s.

Goals:

1. To produce at least one large* and one small** product of scholarly activity over the three years of residency. These should be high quality and contribute to the resident's resume.
2. To engage in the mentoring process both as a mentee and a mentor
3. To be exposed to various types of scholarly activity.
4. To improve fellowship match and job search results

R1: Introduction and dipping the toes

Expectations

- Training in the basics of/ exposure to: case report, research, abstract writing, quality improvement (QI), health policy. This will be accomplished by WES sessions and on-line modules. Each intern will complete 3 modules from the CITI online course.
- Produce one small product of scholarly activity or get started on one large product of scholarly activity.
- Meet with a near-peer mentor to help decide on a scholarly activity and to get their review/thoughts on the product.
- Select faculty scholarly mentor.

R2: Learning to ride the waves

Expectations

- A substantive contribution to the resume. This will include designing and getting feedback on the scholarly activity plan with help for faculty mentor.

R3: Teaching others to swim

Expectations

- Completion of one small and one large product of scholarly activity. If the resident submitted a substantive contribution in R1/R2 year, this may be a smaller project.
- A substantive contribution to near-peer mentoring

* **Examples of larger Scholarly Activity products include:** published manuscripts, oral presentation at national conference, poster at national conference, published case report, resident-initiated QI project, health policy or community-based project (designed and implemented), educational curricula (designed and implemented), global health project (designed and implemented) or any other project of similar scope and quality with APD/PD approval.

**** Examples of smaller Scholarly Activity products include:** submitted abstracts (local, regional or national), submitted case report, clinic QI project or any other project of similar scope and quality with APD/PD approval.

- **Electives**

Our program offers electives in all Internal medicine subspecialty disciplines. In addition, we have a multitude of non-traditional electives that residents can participate in – the full list is available to our residents on the website. [22-23 Resident Course Book](#)

Program Manual Statement

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

GME Policies

[Additional Pay for Additional Work Policy](#)

- [Additional Pay for Additional Work Form](#)

[Concern/Complaint Policy](#)

[Remediation and Disciplinary Action Policy](#)

[Clinical & Educational Work Hours Policy](#)

[Eligibility and Selection Policy](#)

[Evaluation and Promotion Policy](#)

[Grievance Policy](#)

[International Residency Rotations Policy](#)

[Leave Policy](#)

[Medical Records Policy](#)

[Moonlighting Policy](#)

- [Moonlighting Approval Form](#)

[Non-Compete Policy](#)

[Physician Well-Being & Impairment Policy](#)

[Prescriptions: Residents Writing for Staff, Family & Friends Policy](#)

[Professionalism Policy](#)

[Quality Improvement and Patient Safety Policy](#)

[Supervision Policy](#)

[Transitions of Care \(Structured Patient Hand-off\) Policy](#)

[USMLE, COMLEX, & LLMC Examinations Policy](#)

[Work and Learning Environment Policy](#)

Key University of Colorado Policies

[Disability Accommodation Policy](#)

[HIPAA Compliance](#)

[Sexual Misconduct Policy](#)

PROGRAM-SPECIFIC POLICIES

Additional Pay for Additional Work Policy

Additional Pay for Additional Work Policy

In addition to complying with the GME [Additional Pay for Additional Work Policy](#), ([Additional Pay for Additional Work Form](#)) the Internal Medicine program's policies and procedures are:

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

Clinical and Educational Work Hours Policy

Clinical and Educational Work Hours Policy

The Internal Medicine program complies with the ACGME Common and [specialty-specific Program Requirements](#). In addition to complying with [GME Clinical & Educational Work Hours Policy](#), the Internal Medicine program's policies and procedures are:

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

Program Specific Duty Hour Monitoring Process

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

On Call Activities

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

- a. In-house call must occur no more frequently than every third, averaged over a four-week period.

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- b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours for PGY2s and PGY3s. Upper level residents may remain on duty for up to 4 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care (unless further limited by the relevant Program Requirements).
- c. An individual resident may accept no new patients after 24 hours of continuous duty.

Alertness Management and Fatigue Mitigation

The Program Directors, supervising faculty and Chief Medical Residents will monitor for fatigue among residents. Residents are also encouraged to help their peers identify when they are fatigued and step facilitate mitigation resources.

Program Core Faculty as well as residents will receive a presentation about fatigue and warning signs if fatigue could be present and/or impairing work. The program will abide by and enforce the work hours (see either ACGME rules or clinical and work hours policy) such that there is sufficient time to rest in between shifts and after call duties. Backup supervision is available at all times for residents who feel they are impaired by fatigue. An excellent jeopardy system is in place. If at any point a trainee does not feel safe to drive themselves home, they should proceed in taking Lyft or Uber home and for return to work. The Program will reimburse the resident for the expense. **At no point should a housestaff member perform procedures or duties or drive while they knowingly feel overtired or impaired.** Receipts for reimbursement should be sent to jefferson.Velasco@cuanschutz.edu.

Concern/Complaint Policy

Concern/Complaint Policy

To ensure that Residents have a mechanism through which to express concerns and complaints.

Note: For purposes of this policy, a complaint should involve issues relating to personnel, patient care and program or hospital training environment matters.

Policy:

The University of Colorado School of Medicine and Affiliated Hospitals encourage the participation of residents in decisions involving educational processes and the learning environment. Such participation should occur in formal and informal interactions with peers, faculty and attending staff.

Efforts should be undertaken to resolve questions, problems and misunderstandings as soon as they may arise. Residents are encouraged to initiate discussions with appropriate parties for the purpose of resolving issues in an informal and expeditious manner.

With respect to formal processes designated to address issues deemed as complaints under the provisions of this policy, each program must have an internal process, known to

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Residents, through which Residents may address concerns. The Program Director should be designated as the first point of contact for this process. [Anonymous feedback](#) can be provided to the program.

We have a number of mechanisms by which residents are able to provide anonymous feedback to the program and program director:

- [Anonymous feedback portal](#) via the residency website
- Confidential [Resident Liaisons](#)
- Confidential [Faculty Liaisons](#)

If the Resident is not satisfied with the program level resolution, the individual should discuss the matter with the Chair or Division Chief or Section Chief. If no solution is achieved, the Resident may seek assistance from the Graduate Medical Education (GME) Designated Institutional Official (DIO).

1. GME DIO should be consulted. Carol.rumack@cuanschutz.edu or 303-724-6027 (by phone is best for confidential reporting)
2. Housestaff Association (303-724-3039)
3. CUSOM Office of Professional Excellence (303-724-4776)

Eligibility and Selection Policy

Eligibility and Selection Policy

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

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

✓ We generally look for USMLE Step 2 scores at or above the 230 and do expect that the individual will pass the exams in their first attempt. However, each application is reviewed in a holistic approach, taking into account all aspects of the application.

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

✓ We require a chairman's letter and three letters of recommendation with application which is a total of four letters.

✓ You must have graduated from medical school within the last two (2) years (2020). We require International Medical Graduate's to be ECFMG (Educational Commission for Foreign Medical Graduates) certified at the time of your

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application or far enough along in the application process that you will receive certification no later than February 1 of the year in which you plan to match.

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

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

Our deadline for completed applications for 2023 - 2024 is September 28, 2022.

Evaluation and Promotion Policy

Criteria for Promotion & Graduation

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

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

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

Every 6 months (approximately) each resident will meet with his/her assigned APD in the program to review all evaluations and progress to date. This will include a self-evaluation by the resident in advance of these meetings. The APD will then note any areas requiring attention with the resident, and the APD will also forward on a recommendation of promotion, promotion with focus areas, or non-promotion to the Clinical Competency Committee (CCC). The CCC will meet approximately every 6 months and will take a global look at all residents in the program – each committee

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member will be assigned a group of trainees that they have no formal connection with as a secondary review. The CCC will then vote on each resident based on the categories above (promotion, promotion with focus areas, non-promotion). These categories will be forwarded to the PD who will then make a final decision on each trainee every 6 months. All decisions will be reported to the trainees and their APDs as well as the ACGME.

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

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

Advancement from R1 to R2

- Successfully completed R1 rotations. The Program Director and Associate Program Directors will be responsible for reviewing any unsatisfactory evaluations and for determination of any necessary remediation.
- Competent to supervise R1 residents and medical students per Department of Medicine faculty evaluation.
- Able to perform resident duties with limited independence per Department of Medicine faculty evaluation.
- Presentation at Intern's Journal Club completed.
- Has demonstrated sufficient progress in the components of clinical competence that he/she is capable of functioning as a team leader. Specifically, the resident has the necessary skills in data gathering, medical knowledge, clinical insight, and critical thinking to assume a team leadership role. He/she is demonstrating elements of practice-based learning and system-based learning in clinical encounters. No professionalism issues have arisen (see below).
- Has met PGY1 expectations for core competencies as outlined above on page 6.

Advancement from R2 to R3

- Successfully completed R2 rotations. The Program Director and Associate Program Directors will be responsible for reviewing any unsatisfactory evaluations and for determination of any necessary remediation.
- Demonstration of substantial progress on Scholarly Activity

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- Competent to supervise R1 and R2 residents and medical students per Department of Medicine faculty evaluation. All evaluations must be satisfactory or higher.
- Seeks appropriate consultation when indicated.
- Able to perform resident duties with minimal supervision per Department of Medicine faculty evaluation. The resident is capable of making independent decisions based on previous clinical experiences.
- Has the ability to recognize and manage “new” clinical problems (scenarios not previously encountered) skillfully.
- Has met PGY2 expectations for core competencies as outlined above on page 6.

Completion of training

- Successfully completed R3 rotations. The Program Director and Associate Program Directors will be responsible for reviewing any unsatisfactory evaluations and for determination of any necessary remediation.
- Passed USMLE Step 3, if eligible to sit for exam.
- Scholarly work completed
- Prepare and present a peer teaching clinic conference if required, and an article review for journal club.
- Completion of online NEJM Knowledge + modules as assigned.
- Able to perform unsupervised care in the practice of general internal medicine per Department of Medicine faculty evaluation by the end of third year.
- Has sufficient medical knowledge base, problem-solving skills, and clinical judgment that enable him/her to provide satisfactory patient care.
- Has demonstrated practice-based learning and system-based learning in clinical encounters.
- No professionalism issues have been present (see below).
- Has met PGY3 expectations for core competencies as outlined above on page 6.

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

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

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The Internal Medicine **Clinical Competency Committee (CCC)**, is appointed by the program director and meets semi-annually, prior to the residents' semi-annual evaluations. The CCC reviews all resident evaluations, determines each resident's progress on achievement of the specialty-specific Milestones, and advises the program director regarding each resident's progress. All faculty with the exception of the Chief Residents are Core Faculty.

CCC Membership includes:

- Dr. Kathleen Suddarth (Chair of CCC, Associate Program Director)
- Dr. Kathryn Berman (Clinic Director, Westside)
- Dr. Joseph Burke (Associate Program Director)
- Dr. Braidie Campbell (Chief Resident)
- Dr. Sarah Christensen (Clinic Director)
- Dr. Meryl Colton (Chief Resident)
- Dr. Geoffrey Connors (Program Director)
- Dr. Lindsey Davis (Assistant Program Director)
- Dr. Lisa Davis (Associate Program Director)
- Dr. Amira del Pino-Jones (Assistant Program Director for Diversity and Inclusion)
- Ms. Anna Drum-Oden, N.P. (Assistant Clinic Director, VA)
- Dr. Braidie Campbell (Chief Resident)
- Dr. Tyra Fainstad (Clinic Director, Lowry)
- Ms. Nicole Canterbury (Assistant Program Coordinator)
- Dr. Tiffany Gardner (Chief Resident)
- Dr. Emily Gottenborg (Assistant Program Director; Co-Director, Hospital Track)
- Dr. Christine Haynes (Assistant Program Director, Primary Care)
- Dr. Daniel Hepe (Associate Program Director)
- Ms. Elle Contreras (Recruitment Coordinator)
- Dr. Matthew Hoegh (Clinical Instructor, Medicine)
- Dr. Lisa Thompson (Clinic Director, VA)
- Dr. Julia Limes (Associate Program Director; Co-Director, Hospitalist Track)
- Dr. Adrienne Mann (Associate Program Director)
- Dr. Dante Mesa (Chief Resident)
- Dr. Yunan Nie (Chief Resident)
- Dr. Anandi Ramaswami (Clinic Director, Sloan's Lake)
- Dr. Yasmin Sacro (Program Director, Primary Care)
- Dr. Cara Saxon (Chief Resident)
- Dr. Emily Scott (Chief Resident)
- Dr. Jennifer Stichman (Clinic Director, Webb)
- Dr. Lisa Thompson (Clinic Director, VA)
- Ms. Jennifer Weber (Program Administrator)

Any additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. Residents do not serve on the CCC.

The CCC follows the [GME Evaluations & Promotion policy](#). Sources of assessment data reviewed by the CCC include, but are not limited to:

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

At a minimum, the CCC performs the following functions:

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

The program director, or their designee, meets with the resident semi-annually to review the CCC performance report, progress along the milestones, and case logs (if relevant), and designs a learning plan for the resident to capitalize on their strengths and identify areas of growth. For residents failing to progress, the program director develops a plan according to the [Remediation and Disciplinary Action](#) policy. Minutes for the CCC will be taken and kept on file.

Leave Policy

Leave Policy

The program must comply with the current GME [Leave Policy](#), including,

1. Vacation Leave of 4 weeks per PGY (includes leave for education purposes)
2. Sick Leave of 2 weeks per PGY
3. Up to six weeks of approved Family Medical Leave (FMLA) also known as medical, parental and caregiver leave **once and at any time during an ACGME-accredited program** effective the day Resident/Fellow is required to report and with the equivalent of 100% of salary.
 - Vacation/Sick Leave will be used for pay during the first FMLA (if 6 weeks not available – University will supplement)
 - One week of additional paid time off for use outside of the first approved FMLA. This time to be used during the PGY in which the first FMLA is taken.

Extended Leave

Training must be extended to make up any absences exceeding 105 days away from training which includes vacation and sick leave unless special exemption is requested. Residents must be in good standing as determined by the Clinical

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Competency Committee and Program Director for exemption to be requested. Training must be extended under all circumstances for absences exceeding 140 days (including vacation time, sick leave and parental leave). Vacation leave is essential and cannot be forfeited or postponed in any year of training and cannot be used to reduce the total required training period. Residents who take extended leave and will not complete their PGY3 year by August 31st will be ineligible to sit for the ABIM boards for that year. See [ABIM Policies and Procedures](#)

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

Jury Duty

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

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

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

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

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

Parental Rotation Option

With at least 5 months' notice, residents may request 6 weeks of parental leave during the month their child is born. This time will count towards sick leave as well as total time away from training as defined below.

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In order to be paid for the full 6 weeks the resident will utilize two weeks of vacation, and four weeks of NEJM+ rotation or two weeks of sick, four weeks of vacation.

The resident may take six weeks off with part of the time unpaid utilizing two weeks of sick and two weeks of vacation with two weeks unpaid.

In addition, residents who are the primary caretaker for their child may request and additional 4 weeks of either board review or scholarly activity. Residents will be eligible for this elective if they are on track to meet their ACGME and ABIM requirements (including a maximum of 3 non-clinical months). Residents who participate in the board review elective will be required to complete NEJM+ practice questions per the instructions below. Residents who participate in the scholarly activity elective will be required to turn in their scholarly activity. Acceptable scholarly activities are listed below. **It should be noted that residents who choose to participate in both rotations will only be allowed to participate in one other non-clinical rotation during their residency (this includes research months and the chief resident month) per ABIM guidelines.** If additional non-clinical time is needed, then training will need to be extended.

NEJM+ Expectations

1. Residents will complete 200 questions from the NEJM+ question bank.

Possible Scholarly Activities:

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

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7. A quality improvement plan developed by the resident with a faculty mentor (implementation of plan not required, submission must be approved by mentor)

For resident parents who elect to not use these special rotations at the time of their child's birth, up to three days of jeopardy coverage are provided to those on inpatient rotations when their child is born.

Chief residents may request 4 weeks of parental leave using two weeks of vacation and two weeks of sick time. If the chief residents is the primary provider for the child, an additional 6 weeks of work from home may be requested. The program will work with the impacted clinical site regarding work from home accommodations to the best of its ability.

Sick Leave

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

Residents are allowed up to 2 weeks (14 days) away from training (in addition to 4 weeks of vacation) for personal illness/emergency or family illness/emergency/bereavement. Of note, ABIM only allows for 5 weeks of time away from training per year for a total of 105 days of time away from training before the program director must make a special request to the ABIM for the resident to be board eligible. The resident must be in good standing as determined by the Clinical Competency Committee and the program director to make this request. If any resident takes more than 140 days away from training, training will need to be extended.

Vacation Leave Policy:

General:

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

Interns and residents receive 28 calendar days of paid vacation

Each of these weeks must consist of 2 weekend days and 5 week days.

Three of these weeks must be scheduled from Monday through Sunday unless special permission has been given from the Housestaff Office. One of these weeks may be split up in order to accommodate conference attendance and major life events with the permission from the Housestaff Office.

You must take 1 or 2 of these vacation weeks during your clinic-heavy blocks. You must take 1 or 2 vacation weeks during an elective-heavy block unless permission has been given from the Housestaff Office for another arrangement.

Vacations **may not** be taken from ward/required rotations.

You should schedule all of these weeks at the beginning of the year unless you have a special circumstance that you have discussed with the Housestaff Office.

Academic presentations and conference attendance during all electives, including research, count toward your 7 days of vacation.

You cannot take 2 weeks off within a single block without special approval from the Housestaff Office.

Fellows and attendings cannot give permission for additional vacation without approval from the Housestaff Office. If you are absent without providing notification and receiving approval by the Housestaff Office, you may be placed on probation.

If you have an acute need for absence (absence without prior approval) for any reason (including illness) please inform both the Chief Resident and Housestaff Office as far in advance as possible.

The **mandatory In-Training Exam is given in late August and early September**. Please be aware that vacation may be minimized at this time. Vacation and educational leave cannot be carried over to the next academic year.

Intern Basecamp:

Intern Basecamp runs from the last week of June through the first week of July. In general, vacations will not be allowed during basecamp. Special exemptions to this rule will be considered on a case by case basis.

Winter Break:

Winter Break encompasses the consecutive weeks of Christmas and New Year's Day. You may elect to take one of these two weeks as a vacation week. We will attempt to honor which specific week is requested however this is not a guarantee. You will be on wards the opposite week. If you do not elect to take vacation one of these 2 weeks, you will be on your continuity clinic or RAC for one week and on wards the opposite week.

If you do not elect to take vacation one of these 2 weeks, you will be on your continuity clinic for one week and on wards the opposite week.

Change Requests:

All schedule and vacation changes must be confirmed through the Housestaff Office and published on AMION.

Vacation during Elective:

Surveys will be sent out biannually to collect vacation and educational leave **change requests affecting electives** occurring in certain months. These surveys **do not** collect requests to change vacation occurring during clinic.

- Vacations and educational leave in July through December will be considered final upon publication on AMION.
- The survey to solicit changes affecting January through June will be sent out in mid-September.
- Changes requested outside of the survey with between 45 and 90 days' notice will only be approved if the elective can accommodate. These requests should be directed to Nicole.Canterbury@cuanschutz.edu in the Housestaff Office.
- Changes requested with less than 45 days' notice cannot be accommodated, as clinic will have already scheduled patients during your add-back half day.

For changes to **vacation affecting clinic**:

- Changes requested more than 45 days in advance should be submitted to your clinic director first. If the request is approved, email Nicole.Canterbury@cuanschutz.edu in the Housestaff Office with your clinic director cc'ed so it can be updated on AMION.
- Any requests made less than 45 days in advance will be automatically denied due to patients already being scheduled.

If your change affects the jeopardy call system, it is **your responsibility** to arrange for alternate coverage (not the responsibility of the Program or Chief Residents).

Requests for changes to **continuity clinic week half days**:

- Changes to continuity clinic week half days should be submitted to your clinic director at least 90 days in advance and may require you to use vacation time. If you are going to miss a clinic session then in general we will ask you to use a day of vacation to cover that absence.
- Once approved by your clinic director, you should notify the Housestaff office at Nicole.Canterbury@CUAnschutz.edu as this change needs to be recorded.

Leave for Fellowship and Job Interviews:

If you travel for a fellowship or job interview on a weekend that you were otherwise not scheduled to work, you do not owe the program any time or make-up activities. You do need to ensure that you are not on jeopardy.

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Half days count as full days. If you attend an AM clinic and then fly to a job or fellowship interview in the afternoon, that will count as a full day worked. **This policy only applies for fellowship interviews.**

You may miss up to 10 days total during elective time for fellowship and job-related travel/interviewing without any penalty. This is in addition to your annual vacation and educational leave days.

These 10 days may also be used during clinic, RAC, and Geriatrics **if these rotations can accommodate your absence(s)**, but please attempt to schedule your interviews during electives as much as possible. The special rules for each of these other rotations are as follows:

Clinic – as patients are scheduled 45 days in advance, your clinic will likely need to cancel them during your absence. In light of that, please provide your clinic with as much advance notice as possible. Requests will be approved if your clinic can accommodate your absence.

RAC – a minimum of 2 weeks' notice to the chief is required due to patient scheduling needs. Consideration will be given to residents who have a last minute interview come up but it cannot be guaranteed.

ER – this is a graduation requirement, so you need to complete a full complement of ER shifts over the month to get credit for the rotation. However, you will have the ability to arrange your shifts as permitted with the ER schedule, their leadership, and your co-residents in order to accommodate your absences. You cannot “make up” missed ER shifts in any other capacity.

If you are going to miss more than these 10 days during interview season, contact the program director to discuss the potential approval of additional days.

To get credit for any rotation, you have to attend a minimum of 50% of the scheduled days – for example, if you have a week of vacation on an elective, you will only have 5 remaining work days that you can miss.

While you do not need to contact the residency program prior to accepting and scheduling an interview on elective for fellowship or a job, you should let us know **within 24 hours of accepting** so that we can account for your absence. The same applies if you are changing an interview date.

Rules for Coverage Swaps:

- The coverage swaps system can be used by residents for shorter absences related to personal or professional reasons.
- The coverage can be for 1, 2, or 3 days.
- Rules for covering someone else:

- You are not allowed to miss more than 1 day of clinic or more than 3 days of an elective to cover someone else.
- You are not allowed to miss RAC in order to cover for someone else.
- Those on ED cannot miss an ED shift to cover for someone on wards. You should only cover when you are not scheduled for an ED shift.
- Rules for requesting coverage from a co-resident:
 - We encourage you to try to swap with residents on ED or research blocks. The program will provide you with instructions on how to determine which residents are on these rotations in AMION.
 - You are not allowed to request more than 2 coverage swaps during the academic year.
 - You will not be “charged” vacation or educational leave days for a coverage swap.
- Approval Rules:
 - Must be approved by the Chief Residents at impacted sites.
 - Must notify Nicole Canterbury (Nicole.Canterbury@cuanschutz.edu) of any swaps as soon as approved by Chief Residents.
 - Must be arranged at least 3 months in advance.

Moonlighting Policy

Moonlighting Policy

In addition to complying with the GME [Moonlighting Policy](#), and the [Moonlighting Approval Form](#) (found in MedHub → GME Resources and Documents → Finance Forms.), the Internal Medicine program’s policies and procedures are:

- R1 Moonlighting is prohibited at any time without exception.
- R2 Under unusual circumstances of financial need, permission to moonlight may be requested from the Program Director for approval by the Residency Committee. Moonlighting is prohibited while on ward rotations without exception. Moonlighting is strongly discouraged while on specialty rotations.
- R3 Moonlighting is prohibited while on ward and float rotations without exception. Any resident who decides to moonlight while on a specialty rotation should be aware that reports from his/her clinical supervisors

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that moonlighting is interfering with the resident's clinical work will be viewed as significant evidence of irresponsible behavior. Residents who elect to moonlight should be especially careful when setting up their schedules to avoid potential conflicts; e.g., they must not moonlight while on call for some of the subspecialty divisions.

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

Physician Well-Being & Impairment Policy

Physician Well-Being & Impairment Policy

In addition to complying with the [GME Physician Well-Being & Impairment Policy](#), the University of Colorado Internal Medicine Program's policies and procedures are designed to improve trainee well-being and morale.

Residents are given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours in coordination with the program director. Residents have access to confidential, affordable mental health assessment, counseling, and treatment including access to urgent and emergent care 24 hours a day, seven days a week.

Programs and policies are in place to encourage optimal resident and faculty member well-being. These programs include:

- Resident coaching program: All residents are assigned a non-clinical coach to help them navigate what it means to be a physician in training; this coach is non-evaluative and from a specialty into which the resident does not intend to match
- Wellness Curriculum: All interns participate in 5 sessions of wellness training as part of the More than Medicine longitudinal curriculum.
- Wellness Committee. All residents are invited to sit on our resident-led More than Medicine Committee. The committee is in place at the request of

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the Program Director, has faculty oversight and is charged with supporting residents in leading wellbeing initiatives for the program.

- Opt-Out Wellness Visit: All interns are given one half day away from clinic and have an appointment made for them in order to facilitate wellness and lower the bar to mental health care.
- Opt-Out Physician Visit: All interns are given one half day away from clinic and have an appointment made for them with an on-campus primary care physician (outside our department) in order to facilitate primary care provider care for our trainees.
- [Faculty Confidential Advisors](#): The Internal Medicine Residency Program maintains a cohort of confidential advisors, whose names and specialty areas are listed on the Heartbeat website, to whom any resident can turn at any hour of the day.
- [Resident Confidential Liaisons](#): The Internal Medicine Resident Program maintains a cohort of resident liaisons to serve as contacts within the program to help support and provide resources for residents in a time of need.

Other policies that encourage physician well-being include:

- The maintenance and use of a robust backup system so that any resident can ask for and receive help if they are too fatigued to perform their duties
- Assignment of one Chief Medical Resident per year as the “Wellness Chief” to help lead our More than Medicine committee efforts and assure resident wellness is considered in all day to decisions made by residency leadership.
- Creation of a More than Medicine curriculum that is delivered through all years of training in different formats.
- The residency is committed, and provides the residents with monthly reminders, that we will pay for any ride sharing service for any resident who is too tired to drive, both home from the hospital as well as back the following day to retrieve their vehicle.

The program in partnership with the Sponsoring Institution educates faculty members and residents in the identification of the symptoms of burnout, depression, and substance abuse, in themselves and others, including methods to assist those who experience these conditions by requiring that each new resident, fellow and core faculty complete a module on this topic. We also have an annual Department of Medicine M&M conference on physician wellness, our 5-part More than Medicine curriculum, bi-annual burnout screening during the resident’s semi-annual meetings with program leadership and strong encouragement, and central messaging, starting with the R2 transition day talks by the program director, that all senior residents are expected to help care for and monitor the wellbeing of their co-residents and interns.

Self-screening tools for burnout, depression, and substance use disorders are available in MedHub. If another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence, this must be reported to the Program Director, a trusted

Associate Program Director, or to the on-call Chief Medical Resident (who is expected to then report to the Program Director but serves as a safe first contact).

Professionalism Policy

Professionalism Policy

The program complies with the [GME Professionalism Policy](#) and provides a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Residents and faculty are educated regarding unprofessional behavior and are provided with a confidential process for reporting, investigating, and addressing such concerns.

The program director provides a culture of professionalism that supports patient safety and personal responsibility. Residents/Residents and faculty members are educated on sleep deprivation and fatigue to ensure they understand the obligation to be appropriately rested and fit to provide the care required by patients. This is accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, didactic educational events, and/or modules.

Monitoring Resident and Faculty Professionalism

The Program Director monitors resident and faculty compliance with professional standards through direct observation by the Program Director as well as through frequent observation in both inpatient and outpatient care areas by our Chief Medical Residents. We also have the ability to perform and review 360 degree evaluations on both residents and faculty by any member of the care team. Alerts are set up within the MedHub evaluation system to alert the Program Director to any low score, for faculty or residents, which needs to be more immediately addressed.

Monitoring Resident Professionalism

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

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

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

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

The Internal Medicine Residency Program Policy of consequences for noncompliance with program requirements is as follows:

- 1st miss** Email noting the missed deadline and a reminder about the various deadlines in residency; this will help you to find a list of those deadlines known as the '[Residency Roadmap](#)'
- 2nd miss** Email or written notice with offer to speak to Chief Medical Resident and/or Associate Program Director.
- 3rd miss** Email or written notice. Meet with Chief Medical Resident and Associate Program Director.
- 4th miss** Email or written notice. Meet Associate Program Director to discuss the residency requirements upon a 4th missed deadline. Resident advised they will be brought to Clinical Competency Committee for review for ACGME Milestone PROF-2 ("Accepts responsibility and follows through on tasks.").
- 5th miss** Email or written notice. Meet with Dr. Connors. Resident advised they will be brought to Clinical Competency Committee for review for Milestone PROF-2. Focused Review initiated for PROF-2 (not a permanent part of training file). It will be at the discretion of Dr. Connors whether this 5th missed deadline leads to Focused Review or Probationary Status. (Please take note as this is important: if you are placed on Focused Review is not a part of your Permanent training file).
- 6th miss** Email or written notice. Meet with Dr. Connors and Associate Program Director with an option to meet with GME leadership. Clinical Competency Committee review and Focus Review can be assumed, Probation is possible at the discretion of the Program Director. Please note that Probation will be a part of your Permanent training file.

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

Professionalism Education

The program provides the following professionalism education to residents:

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

Social Media Policy

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

Background: We understand that social media can be a fun and rewarding way to share your life and opinions with family, friends and co-workers around the world. However, use of social media also presents certain risks and carries with it certain responsibilities.

In the Hospital: The use of social media is prohibited while performing direct patient care activities, when use would compromise patient confidentiality, and in unit work areas, unless social media use in these areas has been previously approved by a supervisor.

Residents are prohibited from posting anything to social media that could identify a patient unless specific to a work function and the patient or their legally authorized representative has provided appropriate written consent. This includes any posting that contains protected health information (PHI) or anything that if taken collectively with others posts or other publicly known information could identify a patient.

Inappropriate postings that may include discriminatory remarks, harassment, and threats of violence or similar inappropriate or unlawful conduct will not be tolerated and may subject you to disciplinary action.

Ultimately, you are solely responsible for what you post online. Before creating online content, consider some of the risks and rewards that are involved. Keep in mind that any of your conduct that adversely affects your job performance, the performance of fellow residents or otherwise adversely affects members, patients, nurses, etc. may result in disciplinary action. When in doubt, ALWAYS consult your Chiefs and Program Director.

Program Evaluation

Program Evaluation Committee

The **Internal Medicine Program Evaluation Committee (PEC)** is appointed by the Program Director and conducts & documents the Annual Program Evaluation (APE) as part of the program's continuous improvement process. The PEC follows the [GME Evaluations & Promotion policy](#). All faculty with the exception of the Chief Residents are Core Faculty.

PEC Membership:

- Dr. Kathryn Berman (Clinic Director, Westside)
- Dr. Elizabeth Breitbach (POCUS)
- Dr. Joseph Burke (Associate Program Director)
- Dr. Braidie Campbell (Chief Resident)
- Ms. Nicole Canterbury (Assistant Program Coordinator)
- Dr. Sarah Christensen (Clinic Director)
- Dr. Meryl Colton (Chief Resident)
- Dr. Geoffrey Connors (Program Director)
- Ms. Elle Contreras (Recruitment Coordinator)
- Dr. Lindsey Davis (Assistant Program Director)
- Dr. Lisa Davis (Associate Program Director)
- Dr. Amira del Pino-Jones (Assistant Program Director for Diversity and Inclusion)
- Ms. Anna Drum-Oden, N.P. (Assistant Clinic Director, VA)
- Dr. Braidie Campbell (Chief Resident)
- Dr. Brandon Fainstad (Clinic Director, RAC)
- Dr. Tyra Fainstad (Clinic Director, Lowry)
- Dr. Michelle Fleshner (POCUS)
- Dr. Tiffany Gardner (Chief Resident)
- Dr. Emily Gottenborg (Assistant Program Director; Co-Director, Hospital Track)
- Dr. Reem Hanna (Pathway Leader)
- Dr. Janna Hardland (Geriatrics Residents'hip Director)
- Dr. Christine Haynes (Assistant Program Director, Primary Care)
- Dr. Daniel Heppe (Associate Program Director)
- Dr. Jeffrey Hollis (POCUS)
- Dr. Julia Limes (Associate Program Director; Co-Director, Hospitalist Track)
- Dr. Adrienne Mann (Associate Program Director)
- Dr. Dante Mesa (Chief Resident)
- Dr. Neelam Mistry (Clinical Instructor)
- Dr. Noelle Northcutt (POCUS)
- Dr. Carolina Ortiz-Lopez (POCUS)
- Dr. Samuel Porter (Pathway Leader)
- Dr. Yunan Nie (Chief Resident)
- Dr. Anandi Ramaswami (Clinic Director, Sloan's Lake)
- Dr. Yasmin Sacro (Program Director, Primary Care)
- Dr. Ellen Sarcone (Pathway Leader)
- Dr. Cara Saxon (Chief Resident)
- Dr. Emily Scott (Chief Resident)

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- Dr. Jennifer Stichman (Clinic Director, Webb)
- Dr. Kathleen Suddarth (Associate Program Director)
- Dr. Lisa Thompson (Clinic Director, VA)
- Dr. Sarah Wachtel (Director of Advising and Acting Internships)
- Dr. Julie Venci (Med Ped Program Director)
- Ms. Jennifer Weber (Program Administrator)
- Dr. Kelly White (Clinic Director, Anschutz)
- Dr. Chi Zheng (POCUS)
- Dr. Nicholas Bianchina (PGY2 RPEC Leader)
- Dr. Cristina Fischer (PGY2 RPEC Leader)
- Dr. Beret Fitzgerald (PGY2 RPEC Leader)
- Dr. Kira Grush (PGY2 RPEC Leader)
- Dr. Kyle McDaniel (PGY2 RPEC Leader)
- Dr. Savanah Roy (PGY2 RPEC Leader)
- Dr. Rebecca Unterborn (PGY2 RPEC Leader)
- Dr. Francis Zirille (PGY2 RPEC Leader)
- Dr. Megan Calzia (PGY3 RPEC Leader)
- Dr. Alexander Hayden (PGY3 RPEC Leader)
- Dr. Natalie Longino (PGY3 RPEC Leader)
- Dr. Kaitlyn McLeod (PGY3 RPEC Leader)
- Dr. Christopher Mowry (PGY3 RPEC Leader)
- Dr. Lila Steinberg (PGY3 RPEC Leader)

PEC Responsibilities include, but are not limited to:

Acting as an advisor to the program director through

- Program oversight;
- Review of the program's self-determined goals and progress toward meeting them;
- Guiding ongoing program improvement, including development of new goals, based upon outcomes; and
- Review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.

At a minimum, the PEC considers the following elements in its assessment of the program:

- Curriculum
- Outcomes from prior Annual Program Evaluations
- ACGME letters of notification, including citations, Areas for Improvement, and comments
- Quality and safety of patient care

Aggregate resident and faculty

- Well-being
- Recruitment and retention
- Workforce diversity
- Engagement in quality improvement and patient safety
- Scholarly activity
- ACGME Resident and Faculty Surveys

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- Written evaluations of the program

Aggregate resident

- Achievement of the Milestones
- In-training examinations (where applicable)
- Board pass and certification rates
- Graduate performance

Aggregate faculty

- Evaluation
- Professional development

The PEC prepares an Action Plan (per GME Template) documenting initiatives to improve the program, as well as how the initiatives are monitored & measured. The APE Template serves as the minutes for the PEC. The annual review, including the action plan is distributed to and discussed with the members of the teaching faculty and the residents, and is submitted to the DIO.

The Resident Program Evaluation Committee (RPEC) incorporates the resident voice in our PEC and reviews the curricular content of inpatient rotations. This group meets 6 times per year with some of the meetings addressing rotation specific issues with the others dedicated to residency-wide issues (WES, curriculum, noon conferences, etc). RPEC has four leader representatives per class, 1-2 faculty representatives and is open to all housestaff.

Quality Improvement/Patient Safety Policy

Quality Improvement and Patient Safety Policy

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

The program provides formal educational activities that promote *patient safety* related goals, tools, and techniques, including, but not limited to Quality and Safety M&M conference at each site, educational activities designed and implemented by our full time Chief Medical Resident for Quality and Safety, participation by all residents in annual Quality and Safety goals for the Division of Internal Medicine, organized by the DOM Quality and Safety Chief.

Residents will participate in twelve hours of formal quality improvement training during educational half days during their intern year. They will then apply this training to quality improvement projects in their continuity clinics with the assistance of a quality improvement liaison.

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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. Such experiences include a monthly Morbidity and Mortality conference experience.

Residents have the opportunity to participate in interprofessional *quality improvement* activities, such as participation in the residency's Medical Leaders Program, participation in the residency's Hospitalist Training Program Quality and Safety educational series, participation in Medical Grand Rounds, through the feedback obtained through Patient Safety Surveys and through a mandatory, required, mentored quality and safety scholarly work during their three years of training. Residents are also required to complete the IHI online quality and safety modules that are tracked for completion.

The program's activities aimed at reducing health care disparities include the establishment of a new Pathway in Health Equity and Health Disparity open to all residents. We also encourage community service at a number of clinic sites as well as non-clinical, public-health options.

Faculty and residents are responsible for reporting patient safety events, including near misses at clinical sites by using the RL reporting system at the University of Colorado Hospital and similar systems at the other hospitals through which they rotation.

Supervision Policy

Supervision Policy

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

Program Supervision Policy

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

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

The training program is structured such that each resident has a directly assigned supervising attending at all times. All continuity clinic patient

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encounters are directly supervised by an attending physician for the first 6 months of the year, potentially longer depending on determined level of competence. Continuity clinic patient encounters for R2s and R3s are supervised either directly or indirectly based on the complexity of patient care. For inpatient services, all interns will be directly supervised during various portions of the patient encounter during the initial part of the year. In addition, each intern will have one complete patient admission directly supervised during a night admitting shift. Residents and attending faculty are available at all times for trainees.

Supervision of At-Home Call:

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

Supervision Policy Addendum: Moderate Sedation at University of Colorado Hospital

Do Residents/Residents in this program perform Moderate Sedation at UCH?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
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Purpose:

This policy addresses sedation provided for procedures or imaging studies. Sedation administered to treat general medical conditions such as anxiety, sleep disorders or other medical conditions is not covered. Additionally, this policy does not apply to mechanically ventilated or neurologically compromised patients in the intensive care unit.

Qualifications:

1. Exceptions to this policy include board eligible or boarded trainees in anesthesia, emergency medicine, and neonatology.
2. ACLS/ATLS/PALS (whichever is relevant to practice) must be current throughout each year of training during which sedation authorization has been determined by the Program Director for the provision of Moderate Sedation. Programs are responsible for tracking ACLS/ATLS/PALS. (Neonatology – use of sedation under this policy is for ventilated patients only.)
3. Completion of an education module on moderate sedation annually, monitored and confirmed by program director, is necessary for the trainee to be deemed qualified to administer moderate sedation.
 - a. Exceptions - For anesthesia and emergency medicine residents, this only needs to be completed once within 3 months of the start of training.

ULearn Modules: Log into ULearn using username as both login & password. This is usually the same as Epic ID.

Part 1: [Practice](#)

[Guidelines: https://uchealth.certpointsystems.com/lms/basicportal/uchealth/en-US/learner/courses/b6209b66-5716-4e7a-812d-03845050fe14](https://uchealth.certpointsystems.com/lms/basicportal/uchealth/en-US/learner/courses/b6209b66-5716-4e7a-812d-03845050fe14)

Part

[2: Medication: https://uchealth.certpointsystems.com/lms/basicportal/uchealth/en-US/learner/courses/8aa43097-7568-4dde-8b62-8e8540f82dc9](https://uchealth.certpointsystems.com/lms/basicportal/uchealth/en-US/learner/courses/8aa43097-7568-4dde-8b62-8e8540f82dc9)

4. Affirmation of knowledge and understanding of current institutional Moderate Sedation policy by trainee annually, monitored and confirmed by training program.
5. Faculty supervising moderate sedation administered by trainees must have appropriate licensure, credentialing and training per institutional policy on Moderate Sedation.

Minimal Sedation (anxiolysis)*	Level of supervision for any trainee of any level
Description: A drug induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Examples of minimal sedation include peripheral nerve blocks, local or topical	Indirect supervision of the trainee is required. Defined as: supervising physician is not providing physical or

<p>anesthesia, and either (1) less than 50% nitrous oxide in oxygen with no other sedative or analgesic medications by any route, or (2) a single, oral sedative or analgesic administered in doses appropriate for the unsupervised treatment of insomnia, anxiety, or pain. Source: American Society of Anesthesiologists. *Intravenous narcotics are not typically a part of this form of sedation nor is dual agent sedation.</p>	<p>concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.</p>
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*** In the event that anyone assisting with or providing minimal sedation for a patient feels the patient has moved into a deeper level of sedation than intended, they must call the supervising faculty. This must also be documented as an electronic occurrence report (e.g. RL solutions) in the hospital safety reporting system. Consider calling a rapid response if the patient is rapidly deteriorating.**

Moderate Sedation*	Level of supervision for any trainee of any level
<p>Description: A drug-induced depression of consciousness during which a patient responds to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is maintained. Source: American Society of Anesthesiologists.</p>	<p>Direct supervision of the trainee is required for moderate sedation. Defined as: supervising physician is physically present with the resident during the key portions of the patient interactions, and immediately available otherwise (defined as no more than 5 minutes from location). The supervising physician may <u>not</u> be attending to another task that would prohibit them from being available immediately.</p>

***In the event that a patient receiving moderate sedation moves into a deeper level of sedation than intended, the supervising faculty must be called and an electronic occurrence report (e.g. RL solutions) in the hospital safety system must be filed. Consider calling a rapid response if the patient is rapidly deteriorating.**

Emergent/Urgent Situations

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The trainee may attempt moderate sedation, normally requiring direct supervision, in a case where the death or irreversible loss of function of a patient or fetus is imminent, and an appropriate supervisory physician is not immediately available. The assistance of more qualified individuals should be requested as soon as practically possible.

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

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the

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program director and faculty members. The program director evaluates each resident's abilities based on specific criteria, guided by the Milestones. Faculty members functioning as supervising physicians delegate portions of care to residents based on the needs of the patient and the skills of each resident. Faculty supervision assignments are of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility

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

The program provides additional information addressing the type and level of supervision for each post-graduate year in the program that is consistent with ACGME program requirements and, specifically, for supervision of residents engaged in performing invasive procedures -see Housestaff Procedure Supervision on Page 40 of this document.

Guidelines for Circumstances and Events When Residents Must Communicate with the Supervising Faculty Member(s)

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

Clinical Responsibilities by PGY Levels for Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program uses the following classification of supervision:

Direct Supervision:

The supervising physician is **physically present** with the resident during the key portions of the patient interaction; PGY-1 residents must initially be supervised in this manner; or, the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently **monitoring the patient care** through appropriate **telecommunication** technology.

[REQUIRED: residencies with PGY-1s:

- PGY-1 residents must initially be supervised in this manner.
 - A supervising physician must be immediately available to be physically present for PGY-1 residents on inpatient rotations who have demonstrated the skills sufficient to progress to indirect supervision.

Indirect Supervision:

The supervising physician is not providing physical or concurrent visual or audio supervision but is **immediately available** to the resident for guidance and is available to provide appropriate direct supervision.

Oversight:

The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

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**INTERNAL MEDICINE
HOUSESTAFF PROCEDURE SUPERVISION**

As required by ACGME, the program has identified below (with a “1”) when the *physical presence* of a supervising physician is required.

LEVELS OF SUPERVISION				
Trainee will not perform	Supervising physician physically present with resident during key portions of patient interaction (Direct)	Supervising physician not present or providing concurrent supervision, but immediately available to provide guidance and direct supervision (Indirect)	Supervising physician available to provide review & feedback after care is delivered (Oversight)	
NA	1	2	3	
CORE PROCEDURES		R1	R2	R3
Admit patients to service	1	2	2	
Complete H & P	1	2	2	
Treat and Manage	1	2	2	
Make referrals and request consultations	1	2	2	
Provide consultations within the scope of his/her privileges	1	2	2	
Use all skills normally learned during medical school or residency	3	3	3	
Render any care in a life-threatening emergency	1,3	1,3	1,3	
Supervise AHP on service	1	2	2	
SEDATION				
Local Anesthesia	1	2	2	
Moderate Sedation	1	1	1	
GENERAL INTERNAL MEDICINE				
Abscess drainage	1	2	2	
Anoscopy	1	2	2	
Arterial Blood gas	1	2	2	
Arterial Line Placement	1	2	2	
Arthrocentesis	1	2	2	
Aspirations and injections, joint or bursa	1	2	2	
Bladder catheterization	1	2	2	
Bronchoscopy	1	1	1	
Bone marrow aspiration	*1	*1	*1	

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Bone marrow needle biopsy	*1	*1	*1
Cardioversion, emergent	1,3	1,3	1,3
Cardioversion, electives	1	1	1
Central venous catheterization	1	2	2
ECG interpretation panel, emergent	1,3	1,3	1,3
ECG interpretation panel, elective	1	2	2
Exercise treadmill test	1	2	2
ETT with thallium	1	1	1
Excisions/Skin biopsy	1	2	2
Feeding tube placement (nasal or oral)	1	2	2
Rigid Proctoscopy	1	1	1
Laryngoscopy	1	1	1
Lumbar puncture	1	2	2
Pacemaker insertion, transvenous; temporary	1	1	1
Pap smear	1	2	2
Paracentesis	1	2	2
Pericardiocentesis, emergent	1,3	1,3	1,3
Suturing	1	2	2
Tendon/joint injections	1	2	2
Thoracentesis	1	2	2
Tracheal intubation, emergent	1,3	1,3	1,3
Tube thoracostomy	1	1	1
Venipuncture	1	2	2
Peripheral IV placement	1	2	2

All procedures are discussed with the attending prior to proceeding.
Attending Physician (or designated attending) is to be available by phone at all times.
*= fellow in training may serve as supervisor

Transitions of Care Guidelines – Hand-off Process

Transitions of Care (Structured Patient Hand-off) Policy

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

Program Policy for Transition of Care is as follows:

Purpose: To establish a protocol and standards within the Internal Medicine Residency Program to ensure the quality and safety of patient care when transfer of responsibility for a patient occurs.

Transition of care occurs regularly in the program under the following conditions: (check all that apply)

- Change in level of patient care, including inpatient admission from the ambulatory setting, outpatient procedure, or diagnostic area
- Inpatient admission from the Emergency Department
- Transfer of a patient to or from a critical care unit
- Transfer of a patient to or from the Post Anesthesia Care Unit (PACU) or operating room
- Transfer of care to other healthcare professionals within procedure or diagnostic areas
- Discharge, including discharge to home or another facility such as skilled nursing care
- Change in provider or service, including during shift or rotation changes (e.g. resident sign-out, inpatient consultation sign-out, etc.) and patient panel handovers at graduation
- Other _____

Patient hand-overs must include the transmission of specific informational items. These include: (check all that apply)

- Attending physician and upper level residents responsible
- Admission date and admitting diagnosis
- Diagnosis and current status/condition (level of acuity) of patient
- Important elements of history and physical examination
- Relevant social information including contacts
- Dates and titles of operative procedures, if any
- Current medication list
- Key information on current condition and care plan (diet, activity, planned operations, pending discharge, significant events during the previous shift, changes in medications etc.)
- Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
- Outstanding tasks – what needs to be completed in the immediate future

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Specific tasks that need to be accomplished by the resident that is taking over such as following up on laboratory and imaging studies, wound care, clinical monitoring, pending communication with consultants, etc.

Changes in patient condition that may occur requiring interventions or contingency plans

Code status, advance directives

Other _____

The structure or mnemonic tool utilized by the program for handoffs:

IPASS

SBAR

SIGNOUT

Other: Structured formats for discharge summaries and transfer summaries at each hospital

Program Policy for Transition of Care is as follows:

The program optimizes transitions in patient care, including their safety, frequency, and structure by having the following processes and procedures in place:

1. Time/Place

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

2. Structure/Protocol

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

out and keep it updated and the interns have the opportunity to practice verbal sign out using the written sign out.

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

4. **The overnight cross-cover provider (resident or intern) is working 4-7 nights in a row in order to maximize continuity with cross-covering patients.**

5. **Transitions of Service**

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

6. **End of Rotation Transition**

End of rotation handoffs will involve either written or verbal sign out between residents. Attending switch days will be staggered on almost all rotations to provide continuity of care for the team.

The program monitors effective, structured hand-offs by having the interns observed by the senior residents and the senior residents providing feedback and guidance.

The program ensures residents are competent in communicating with the team members in the hand-over process through evaluation.

1. Each resident is expected to use the designated structured handoff process at each site for every patient. In the units, the handoff process will often be monitored directly by the fellow or attending on service, and on the inpatient wards the attending physicians will monitor the process frequently (especially early on in the year) as well as audit written sign outs.

2. Transitions of care are evaluated on monthly inpatient rotations.

The program and clinical sites maintain and communicate schedules of attending physicians and residents/residents, currently responsible for care, by ensuring that

all call schedules and contact information is available in Amion and using the Epic treatment team functionality.

The program ensures continuity of patient care, consistent with the program's policies and procedures in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency by deploying jeopardy coverage if needed. Additional support or direction will be implemented if needed by contacting the Chief Resident on call as noted in Amion.

USMLE (and COMLEX) Examinations

Policy on USMLE (and COMLEX) Examinations

In addition to complying with the GME [USMLE, COMLEX, & LLMC Examinations Policy](#), the Internal Medicine program's policies and procedures are:

1. USMLE Step 3 must be completed in PGY1 year.
2. USMLE Step 3 examinations are to be scheduled during an elective rotation. If this is not feasible, with 4 months' advanced notice, the exam can be scheduled during a clinic or ambulatory block. Once your exam has been scheduled, you must notify Mary Meadows at Mary.Meadows@cuanschutz.edu and your rotation director of your scheduled dates. A copy of your USMLE score needs to be provided to Mary Meadows at Mary.Meadows@cuanschutz.edu in the Housestaff Office. Details for scheduling [USMLE](#) can be found on our website.

Medical Student Learning Objectives

Adult Ambulatory Care (AAC) Learning Goals

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

6. Develop professional attributes and lifelong learning skills.

Learning Objectives

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

Hospitalized Adult Clerkship (HAC) Goals and Objectives

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

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

Students are expected to be able to interpret the following clinical tests:

- ABG, BMP, ECG, Chest X-Ray, Cardiac Enzymes

Students also have the following objectives they should be able to complete by the end of the 8 week rotation:

- Complete written and oral communications that are organized, accurate, complete, concise, and incorporate prioritization and analysis of medical issues
- Discuss advanced directives and DNAR orders with patients and families
- Deliver difficult news including information regarding diagnosis and prognosis
- Demonstrate collaborative decision making
- Obtain a medical consultation from and communicate with subspecialty colleagues

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- Perform peri-discharge education for a patient
- Demonstrate a commitment to carrying out professional responsibilities in a timely and efficient manner
- Interact respectfully with ALL members of the health care team
- Demonstrate sensitivity to a diverse patient population and provide culturally competent care
- Develop skills in team-based care (incorporating PT, OT, SLP, SW, CM, etc.)
- Understand some of the costs of an inpatient hospitalization
- Understand the resources available to patients upon discharge from the hospital

Understand the common pitfalls associated with transitions in medical care from one setting to another

ACGME Specific Program Requirements

The program will incorporate the current [Accreditation Council for Graduate Medical Education](#) program requirements within this Program Manual annually.

[ACGME Internal Medicine Program Requirements](#)