University of Colorado School of Medicine
Internal Medicine Program

PROGRAM HANDBOOK AND POLICY MANUAL

ACGME-Accredited Program

2025-2026

Contents

University of Colorado School of Medicine

Internal Medicine Program

Program Personnel and Contact Information

Julia Limes, M.D.
Associate Professor of Medicine
Program Director, Internal Medicine
Department of Medicine
Phone: 303-724-1788
Fax: 303-724-1799
Julia.Limes@cuanschutz.edu

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

Program Administration and Leadership

Administrative Staff	Role	Phone
Kendra Burghardt Kendra.Burghardt@dhha.org	Primary Care Track Coordinator	303-602-0494
Nicole Canterbury-Passoth Nicole.CanterburyPassoth@cuanschutz.edu	Assistant Program Admin Schedules, PLAs, Visas	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
Kendra Lewis Kendra.Lewis@cuanschutz.edu	Leave and Fellowship	303-589-3541
Matthew Konjoian Matthew.Konjoian@cuanschutz.edu	Student Rotations, Ed Funds, POCUS and Semi-Annuals	303-724-1790
Mary Meadows Mary.Meadows@cuanschutz.edu	Program Requirements, PSTP and Verifications	303-724-1784 (main number)
Jefferson Velasco Jefferson.Velasco@cuanschutz.edu	Evaluation and Curriculum, Resident Travel	303-724-1791
Jennifer Weber Jennifer.Weber@cuanschutz.edu	Program Administrator	303-724-1788

Chief Residents	Role	Phone
Julia Bast Julia.Bast@cuanschutz.edu	Chief Residents	608-732-6373 (c)
Ellen Brinza Ellen.Brinza@cuanschutz.edu	Chief Residents	248-721-3085 (c)
Brittany Denzer Brittany.Denzer@cuanschutz.edu	Chief Residents	720-722-1803 (c)
Minh Do Minh.Do@cuanschutz.edu	Chief Residents	713-732-1940 (c)

Emily Lowe Emily.Lowe@cuanschutz.edu	Chief Residents	502-802-9718 (c)
Timothy McGinnis Timothy.E.McGinnis@cuanschutz.edu	Chief Residents	303-907-1526 (c)
Gavi Roda Gavi.Roda@cuanschutz.edu	Chief Residents	720-299-6799 (c)

Faculty	**Role**	**Phone**
Elizabeth Breitbach, MD Elizabeth.Breitbach@va.gov	Assistant Program Director, Neuro Prelims	507-884-6210 (c)
Joseph Burke, MD Joseph.Burke@dhha.org	Associate Program Director DHHA Site Director	303-602-4027 303-547-8359 (c)
Hoda FarapjourBakhtiari, M.D. Hoda.FarapjourBakhtiari@cuanschutz.edu	Assistant Program Director for Diversity and Inclusion	303-301-4749 (c)
Daniel Gergen, MD Daniel.Gergen@cuanschutz.edu	Assistant Program Director, UCH Site Director and Scheduling	512-422-7188 (c)
Emily Gottenborg, M.D. Emily.Gottenborg@cuanschutz.edu	Associate Program Director Director, Hospitalist Track	610-608-8303 (c)
Andi Hudler, MD Andi.Hudler@dhha.org	Associate Program Director. CAT Residents, Fellowship and Scholarship Support	719-342-9437 (c)
Christine Haynes, M.D. Christine.Haynes@dhha.org	Assistant Program Director Primary Care	303-436-4209
Daniel Heppe, M.D. Daniel.Heppe@va.gov	Associate Program Director VA Inpatient	720-771-0667(c)
Julie Knoeckel, M.D. Julie.Knoeckel@dhha.org	Assistant Program Director Community Engagement	720-273-8451 (c)
Julia Limes, M.D. Julia.Limes@cuanschutz.edu	Program Director	303-724-1788 720-470-3306 (c)
Yasmin Sacro, M.D. Yasmin.Sacro@dhha.org	Associate Program Director, Program Director, Primary Care	303-602-5446
David Schwartz, M.D. David.Schwartz@cuanschutz.edu	Program Director, PSTP	303-724-1780
Joshua Smith, MD Joshua.Smith@cuanschutz.edu	Associate Program Director, CAT Residents, Fellowship Support and UCH Site Director	720-848-2241 720-432-2083 (c)
Karen Stenehjem, M.D. Karen.Stenehjem@cuanschutz.edu	Associate Program Director VA Outpatient	912-272-7774 (c)
Kathleen Suddarth, M.D. Kathleen.Suddarth@cuanschutz.edu	Senior Associate Program Director	720-848-2382 303-877-9835 (c)
Manny Urra Manuel.Urra@cuanschutz.edu	Assistant Program Director, WES	305-302-6230 (c)

Program Mission and 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 career aspirations 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 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 value most: empathy, inquiry, dedication, responsibility and professionalism to best prepare them to care for the communities they will serve.
- We aim to create a learning environment that values inclusion and diversity.
- We aim to recruit and retain residents, faculty and staff from diverse backgrounds and identities so that our program reflects the communities we serve.

Program Curriculum

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

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

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

Patient Care and Procedural Skills
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to demonstrate the ability to manage patients:

1. 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;
    a. In the prevention, counseling, detection, and diagnosis and treatment diseases commonly seen in internal medicine;
    b. In a variety of health care settings to include the inpatient ward, the critical care units, the emergency setting and the ambulatory setting;
    c. 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;
    d. Using clinical skills of interviewing and physical examination;
    e. By caring for a sufficient number of undifferentiated acutely and severely ill patients.

2. Residents must be able to competently perform all medical and diagnostic procedures considered essential for the area of practice. Residents:
    a. Are expected to demonstrate the ability to manage patients:
    b. Using the laboratory and imaging techniques appropriately
    c. They must treat their patient's conditions with practices that are safe, scientifically based, effective, efficient, timely, and cost effective.

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. Knowledge of the broad spectrum of clinical disorders seen in the practice of general internal medicine

2. 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.

3. Are expected to demonstrate sufficient knowledge to
    a. Evaluate patients with an undiagnosed and undifferentiated presentations
    b. Treat medical conditions commonly managed by internists
    c. Provide basic preventive care;
    d. Interpret basic clinical tests and images;

e. Recognize and provide initial management of emergency medical problems;
f. Use common pharmacotherapy;
g. Appropriately use and perform diagnostic and therapeutic procedures.

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.
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;
2. Set learning and improvement goals;
3. Identify and perform appropriate learning activities;
4. Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
5. Incorporate formative evaluation feedback into daily practice;
6. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
7. Use information technology to optimize learning;
8. Participate in the education of patients, families, students, residents and other health professionals.

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.
Residents are expected to:

1. Communicate effectively with patients and families;
2. Communicate effectively with physicians, other health professionals, and health related agencies;
3. Work effectively as a member or leader of a health care team or other professional group;
4. Act in a consultative role to other physicians and health professionals;
5. Maintain comprehensive, timely, and legible medical records.

Professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
Residents are expected to demonstrate:

1. Compassion, integrity, and respect for others;
2. Responsiveness to patient needs that supersedes self-interest;
3. Respect for patient privacy and autonomy;

4. Accountability to patients, society and the profession;

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.
Residents are expected to:

1. Work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2. Coordinate patient care within the health care system relevant to their clinical specialty;
3. Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population- based care as appropriate;
4. Advocate for quality patient care and optimal patient care systems;
5. Work in interprofessional teams to enhance patient safety and improve patient care quality;
6. Participate in identifying system errors and implementing potential systems solutions
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;
8. Recognize and function effectively in high-quality care systems.

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

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

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

ACGME CORE COMPETENCIES- Expectations for performance by PGY level

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

PGY I:

1. Performance of comprehensive history and physical examination
2. Synthesis of data into problem list and formulation of diagnostic plan with some supervision

3. Daily patient progress notes and close follow up of diagnostic tests/interventions
4. Daily communication with supervising attending physician
5. Effective communication skills accompanied by respectful and professional behavior in all interactions with patients and families

PGY 2 and 3:

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

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

PGY I:

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

PGY 2 and 3:

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

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

PGY 1:

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

PGY 2 and 3:

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

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

PGY 1,2 and 3:

1. Development of strong language and documentation skills
    a. Succinct and comprehensive case presentations 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 professional appearance
3. Commitment to ethical principles pertaining to confidentiality of patient information, informed consent
4. Compliance with all HIPAA regulations (training provided at orientation)
5. Commitment to professional responsibility in the completion of all medical records in a timely fashion
6. Demonstration of a sensitivity to cultural differences, preferences
7. 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

Goals and Objectives for Each Assignment at Each Educational Level, including for elective rotations

Goals and objectives for all rotations are found on the **IMRP Teams site in Rotation Goals and Objectives.**

ACGME specialty-specific requirements
ACGME Program Requirements

ACGME specialty-specific milestones
Internal Medicine Milestones

Block Diagram in ACGME Format

Note: this is a sample of the rotations (listed by site) of experiences to be scheduled during the program. Your Individual rotation schedules are available on Amion and in MedHub

25-26 Sample Block Schedule 8.13.25.pdf

Didactics and Conferences

Residents are provided with protected time to attend didactic sessions during ambulatory blocks and clinic weeks, held every Wednesday morning for four hours. These sessions align with ACGME requirements for Internal Medicine Residencies, focusing on core internal medicine knowledge.

Curriculum Delivery

- In-person lectures
- Asynchronous online learning via AMBOSS Modules

Conference Types

- Wednesday morning ambulatory block sessions
- Hospital-based conferences
- Continuity clinic conferences
- Subspecialty conferences (during inpatient/elective rotations)
- Monthly journal club, clinical pathologic conference, and morbidity & mortality conference

Attendance Policy

- Attendance is mandatory for all residents unless on vacation or sick leave.
- Completion of assigned AMBOSS modules is required annually.
- Attendance is prioritized across all housestaff.

Access and Logistics

- WES schedules are available on the IMRP Teams site (**WES**).
- Weekly calendar invites include session details: location, topic, prework, and speaker.
- Post-session evaluations are distributed via link.
- Presentation materials are archived in the Teams site under R1 or R2-3 folders for AY 25–26.

Research and Scholarly Activities/Requirements

Residents are required to complete one large and one small scholarly activity project during residency. Specific details and examples of projects are provided to the residents during our educational half day and housed on the IMRP Teams site

1. Exceptions to this:
    a. Residents are able to complete 2 or more large projects instead of 1 small and 1 large if this better aligns with their career goals and interests

   b. Residents whose career paths align with community clinicians can opt to do 1 small project and add additional continuity clinic time in place of scholarly activity with approval from their APD mentor and the PD.
   c. PSTP residents who are short tracking are only expected to complete 1 small or large project by the end of residency.
2. Residents are required to:
   a. List updates with their scholarly activity progress in their semi annual self evaluations, to be reviewed by their APD mentor.
   b. Complete 1 Works in Progress or Journal Club presentation in their individual tracks in their PGY2 year.
   c. Present their scholarly activity or clinical review at Senior Grand Rounds during the spring of their PGY3 year.
3. Scholarly activity requirements are sent to the residents via email, discussed in the educational half day, discussed in housestaff meeting, listed on the residency roadmap, and available to reference on the IMRP Teams site.
4. Support for scholarly activity includes:
   a. Funds to attend conferences to present their scholarly work – each resident has, in addition to their educational funds, $1500 in conference funding over the 3 years with the opportunity to apply for more.
   b. One half day per week during their continuity clinic blocks built in for scholarly activity (12 half days per year).
   c. The opportunity to do 2-3 research electives over the course of their 3 years.
   d. APD mentorship and guidance, and support from the subspecialty research coordinators or faculty liaisons in each subspecialty.

Sample/example of program evaluation forms

25-26 Faculty
Evaluation of Residen

Program Manual Statement

The Internal Medicine program complies with Accreditation Council for Graduate Medical Education (ACGME) and University of Colorado School of Medicine (CUSOM) Graduate Medical Education (GME) policies, procedures and processes that are available on the GME website. Direct access to key GME policies are available by clicking the hyperlinks below.

The program reviews all GME and program policies, procedures and processes at least annually with residents/fellows.

Key GME Policies

Additional Pay for Additional Work Policy

Clinical & Educational Work Hours Policy

Concern/Complaint Policy

Disaster Policy (no program specific policy)

Drug Test Policy (no program specific policy)

Educational Funds

Eligibility and Selection Policy

Evaluation and Promotion Policy

International Residency Rotations Policy

Leave Policy

Medical Records Policy (no program specific policy)

Moonlighting Policy

Non-Compete Policy (no program specific policy)

Physician Well-Being & Impairment Policy

Prescriptions: Residents Writing for Staff, Family & Friends Policy (no program specific policy)

Professionalism Policy

Quality Improvement and Patient Safety Policy

Remediation, Disciplinary Action and Grievance Policy (no program specific policy)

Supervision Policy

Telehealth: GME Residents Performing Telehealth Patient Care (no program specific 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, Intimate Partner Violence, and Stalking Policy

PROGRAM-SPECIFIC POLICIES

Additional Pay for Additional Work Policy

Last revised by program 6/20/2025

The Internal Medicine Program complies with the GME **Additional Pay for Additional Work Policy**.

The Internal Medicine *program's policies and procedures are:*

☒*The program allows additional pay for additional work*

In addition to complying with the GME **Additional Pay for Additional Work Policy**, (**Additional Pay for Additional Work Form)** This document can be found in MedHub a GME Resources and Documents and Finance Forms. 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.

Additional pay documents are renewed annually. The Program will send updated forms to PGY3 residents in June to complete if they want to participate in additional work opportunities. Residents may not sign up for shifts until their form has been fully executed through the GME Office. If you have any questions about this process, please contact Mary.Meadows@cuanschutz.edu

Clinical and Educational Work Hours Policy

Last revised by program 6/20/2025

The Internal Medicine program complies with the ACGME Common and *specialty-specific* Requirements in addition to complying with **GME Clinical & Educational Work Hours Policy**

The Internal Medicine program's policies and procedures are:

Program Specific Work Hour and Call Monitoring Process

The program monitors and reports resident clinical and education work hours through monthly surveys sent out by GME. All residents 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 works promptly and proactively with hospital sites, service directors and the Resident Program Evaluation Committee to address work hour issues.

Our program no longer has any 24-hr call shifts and does not have home call outside of 1 week of home call while on geriatrics rotation.

Maximum Hours of Clinical and Educational Work per Week Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Clinical Work and Education: Residents should have eight hours off between scheduled clinical work and education periods.

Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks).

Alertness Management and Fatigue Mitigation

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

Program Core Faculty as well as residents will receive a presentation about fatigue and warning signs of fatigue and if it 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 always available 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 driving home, they should proceed by taking Lyft or Uber home and returning 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 Matthew.Konjoian@cuanschutz.edu.

Concern/Complaint Policy

Last revised by program 6/20/2025

Each program must have internal mechanisms and individuals, known to Residents, through which Residents **have the opportunity to raise concerns, report mistreatment and provide feedback in a confidential manner as appropriate without fear of intimidation or retaliation.**

See the CU GME-wide Concern/Complaint Policy for options available to all residents and fellows. Contacts listed in the policy include:

- GME Associate Dean/ACGME DIO
    a. (Geoffrey.Connors@cuanschutz.edu)
    b. an anonymous reporting link to the GME Associate Dean/ACGME DIO on the GME website: https://ucdenverdata.formstack.com/forms/anonymous_report.
- CUSOM Office of Faculty Relations (303-724-4776)
- CUSOM Office of Equity (303-315-2567)
- CUSOM Office of Diversity, Equity, and Inclusion
- CUSOM Ombuds Office (303-724-2950)

Additional information can be found online at Resident Guide to Reporting a Problem or Concern.

In addition to the above GME-wide mechanisms, the Internal Medicine program's additional reporting structures and individuals include:

- Reporting directly to the Program Director, assigned Associate Program Director mentors, or Chief Medical Residents (see contact information above)
- Confidential rotation evaluations – viewed by Program Director, Associate Program Directors, and chief residents
- Confidential attending evaluations – viewed by Program Director and anonymously reviewed by Safe Learning Environment Committee
- Resident Program Evaluation Committee
- Anonymous feedback can be provided to the program, viewed by Program Director, Senior Associate Program Director, and Program Administrator.
- Confidential Resident Liaisons
- Confidential Faculty Liaisons

If the concern or complaint involves the Program Director and/or cannot be addressed to the Program Director, residents can contact the program's appointed trusted faculty confidential advisors linked above.

If the Resident is not satisfied with the program level resolution, the individual should discuss the matter with the Graduate Medical Education (GME) Designated Institutional Official (DIO).

Educational Funds Policy (new 2025-2026)

Last revised by program 6/20/2025

Per the GME Resident Educational Funds Policy, Program Directors have discretion to determine if the funds will be pooled for department-level expenses or disseminated to the Residents for individualized expenses.

☒ The **Internal Medicine Program** disseminates funds for individualized Resident expenses to all Residents in the program with the following conditions:

Approved uses:

- *MKSAP, other similar board review materials, textbooks, study aids*
- *Educational organization membership dues, i.e., American College of Physicians or a subspecialty society*
- *Travel expenses while at educational conferences (registration, per diem, hotel, flights)*
- *Medical equipment (ex: stethoscopes)*
- *Bibliography/citation reference manager software (ex: EndNote, Biblioscape, Reference Manager, etc.)*
- *Licensing and exam fees (Boards, Step3)*

Receipts ***must fall within*** the academic year the funds are issued and must be dated between **7/1/25** and **5/31/26**. ***The deadline to use your funds for each academic year is May 31st.***

***Receipts** should provide the name of the purchaser, the company that items were purchased from, the itemized purchase(s), the date, your name as the purchaser, the method of payment (last four digits of the credit card number) and that the balance is now zero because it was paid in full. If the purchase was made more than 90 days from the time it is submitted, the reimbursement will be considered taxable income.

Please submit all receipts for reimbursement to **Matthew.Konjoian@cuanschutz.edu**. If you have any questions regarding the validity of your purchase, contact Matt **before** you make purchases.

Med/Peds residents, please provide your expenses to **Akemi.Iwanabe@cuanschutz.edu**

Eligibility and Selection Policy

Last revised by program 6/20/2025

University of Colorado School of Medicine

Internal Medicine Program

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements in addition to complying with GME **Eligibility and Selection Policy**.

The Internal Medicine program's policies and procedures are:

Our approach to selecting applicants:

- We review the entire application and take into account multiple factors when deciding who to interview and select, including:
  - Varied life experiences
  - Medical school performance (with a focus on clerkships and in particular the medicine clerkship and medicine sub-internship)
  - USMLE Step 2 or COMLEX scores
  - Community involvement and engagement
  - Scholarly work
  - Demonstration of leadership qualities.
- We do not have a set USMLE or COMLEX cut-off score; however, most of our applicants score above 235 on USMLE Step 2. We expect that individuals have passed the exams in their first attempt and performed competitively. We do accept COMLEX scores in lieu of USMLE. The minimum required COMLEX score is 600.
  - **USMLE Step 2 scores are not required at the time of application, but exam must be taken by December 2025 to be considered for ranking.**
  - **For international medical graduates, USMLE Step 3 scores are not required at the time of application, but exam must be taken by December 2025 to be considered for ranking.**
- We strongly recommend having one month of clinical rotation experience in a U.S. healthcare system. Tele-rotations do count as clinical experience. Observerships and research experiences are not considered clinical rotation experience.

Requirements:

- We will accept only applications submitted to us electronically through ERAS. If you are an international medical graduate, you must apply to our program through an ECFMG office.
  - We **are** utilizing program signals for the 2025-26 application cycle
  - We will **not** accept any applications sent to us in ERAS after 4pm on **Thursday, October 2nd, 2025.**

- We require a chairman's letter and three letters of recommendation, which is a total of 4 letters.
    - Chairman's letter is optional for preliminary applicants.
    - For those applying after serving in the armed forces after medical school graduation, we require a chairman's letter from your time at medical school and strongly suggest one of your letters of recommendation be from your current commanding officer.
- Residents in our program must be a U.S. citizen, lawful permanent resident, refugee, asylee, or possess the appropriate documentation to allow a resident to legally train at the University of Colorado School of Medicine.
- Residents in our program must be vaccinated against all standard vaccine series required to work in a medical environment.
- International Medical Graduates:
    - Applicant must be ECFMG certified at the time of your application or far enough along in the application process that you will receive certification no later than February 1 of the year in which you plan to match.
    - Must complete their Step 3 exams by December 31st prior to the match.

Entry Requirements:

The Department of Medicine at the University of Colorado does not discriminate with regard to age, sex, race, religion, national origin, disability, or Veteran status.

- Certification by the National Board of Medical Examiners (NBME), the National Board of Osteopathic Medicine (NBOME), or the Educational Commission for Foreign Medical Graduates (ECFMG) is required.
- International medical graduates must hold a valid ECFMG certificate, have a full, unrestricted license to practice medicine in a U.S. licensing jurisdiction, or have completed a Fifth Pathway program provided by an LCME-accredited medical school.

The University of Colorado School of Medicine recognizes that housestaff enrolled in its program are trainees, not employees. As such, applicants also must be able to meet the conditions of the school's Houseofficer Training Agreement. Specifically, they must:

- Be a U.S. citizen or hold a valid U.S. resident alien card
- Possess (or be eligible to obtain) all three of the following:
    - Valid passport

  - Valid 1-94 card (obtained upon entry to the U.S.) that indicates D/S J-1 (Duration of Status for J-1 visa);
  - J-1 visa or H1B visa sponsorship from the ECFMG to train at the University of Colorado School of Medicine in the Department of Medicine.
- Eligible for a physician training license as granted by the Colorado Medical Board.
- In accordance with the CU GME USMLE, COMLEX, and LMCC Examination Policy, applicants must have successfully completed the USMLE Step 1 and USMLE Step 2 (CK and CS) examinations, or the COMLEX Level 1 and COMLEX Level 2 examinations, as evidenced by obtaining a passing grade for the examinations prior to starting a residency.

Selection Criteria:

- We look for ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity, and the ability to function within parameters expected of a practitioner in the specialty.
- We aim to recruit and retain residents to provide the best possible care for the communities we serve.
- To determine the appropriate level of education for individuals wishing to transfer from another training program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to acceptance into the program.
- We will review and select applicants in a manner consistent with provisions of equal opportunity employment and will not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.
- We participate in the National Resident Matching Program (NRMP).

Resident and Faculty Involvement in Recruitment/Retainment Efforts

We encourage all residents to be involved in our recruitment process. They are involved in recruitment events before interview season, highlighting the program on social media, reaching out to their medical schools, participating in small group sessions and large group panels with applicants on interview days, participating in educational sessions highlighted on interview days, and are available for applicant questions after interview days. We engage all APDs and Core Faculty in our recruitment efforts including application review, recruitment events, interview days, and ranking committee meetings. We solicit interest from all faculty within the Department of Medicine and in total we have over 100 unique faculty involved in interviewing applicants for residency.

For retention efforts, we provide multiple levels of mentorship including APDs, Chief Residents and individualized mentorship for scholarship. Each intern is assigned a non-clinical coach and has the opportunity to partake in Better Together, a national coaching program with the opportunity for additional individual coaching. In addition, we hold many community building events which are open to all members of our residency community (residents, program leadership, and faculty).

Evaluation and Promotion Policy

Last revised by program 6/20/2025

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements in addition to complying with the GME **Evaluation and Promotion Policy**.

The Internal Medicine program's policies and procedures are:

Criteria for Promotion & Graduation

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
  - Participation in scholarship.
- Timely completion of all dictations and assignments
- Completion of all GME modules and any program-specific modules assigned
- Self-evaluation

Approximately every 6 months 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 from the resident, and the APD will also forward a recommendation of promotion, promotion with focus areas, or non-promotion to the Clinical Competency Committee (CCC). The CCC will meet approximately every 6 months and will take a global look at all residents in the program – each committee member will be assigned a group of trainees that they have no formal connection with 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 based on 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 study 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 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 beginning on page 8.

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 determining any necessary remediation.
- Demonstration of substantial progress on Scholarly Activity
- 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 can make 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 9.
- Passed USMLE Step 3, by December of PGY2 year.

Completion of training

- Successfully completed R3 rotations. The Program Director and Associate Program Directors will be responsible for reviewing any unsatisfactory evaluations and determine if any remediation is necessary.
- Scholarly work completed.
- Prepare and present a peer teaching clinic conference if required, and an article review for journal club.
- Completion of online AMBOSS 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.

Clinical Competency Committee

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 except for the Chief Residents are Core Faculty.

CCC Membership includes:

- Dr. Kathleen Suddarth (Chair of CCC, Associate Program Director)
- Dr. Julia Bast (Chief Resident)
- Dr. Kathryn Berman (Clinic Director, Westside)
- Dr. Elizabeth Breitbach (Assistant Program Director)
- Dr. Ellen Brinza (Chief Resident)
- Dr. Joseph Burke (Associate Program Director)
- Dr. Michael Castellarin (Clinic Director, VA)
- Ms. Elle Contreras (Recruitment Coordinator)
- Dr. Brittany Denzer (Chief Resident)
- Dr. Minh Do (Chief Resident)
- Ms. Anna Drum-Oden, N.P. (Assistant Clinic Director, VA)
- Dr. Tyra Fainstad (Clinic Director, Lowry)
- Dr. Hoda Farajpourbakhtiari (Assistant Program Director CORE)
- Dr. Daniel Gergen (Assistant Program Director)
- Dr. Emily Gottenborg (Associate Program Director; Director, Hospital Track)
- Dr. Christine Haynes (Assistant Program Director, Primary Care)
- Dr. Daniel Heppe (Associate Program Director)
- Dr. Andi Hudler (Associate Program Director)
- Dr. Julia Limes (Program Director)
- Dr. Emily Lowe (Chief Resident)
- Dr. Timothy McGinnis (Chief Resident)
- Dr. Anandi Ramaswami (Clinic Director, Sloan's Lake)

- Dr. Gavi Roda (Chief Resident)
- Dr. Yasmin Sacro (Program Director, Primary Care)
- Dr. Joshua Smith (Associate Program Director)
- Dr. Nicole Soiseth (Clinic Director, Webb)
- Dr. Karen Stenehjem (Associate Program Director)
- Dr. Benjamin Trefilek (Clinic Director)
- Dr. Jackson Turbyfill (Core Faculty)
- Dr. Manuel Urra (Assistant Program Director)
- Mr. Jefferson Velasco (Evaluation and Curriculum Coordinator)
- Ms. Jennifer Weber (Program Administrator)
- Dr. Kelly White (Clinic Director, Anschutz Clinic)

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:

- 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.

Minutes for the CCC will be taken and kept on file.

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.

- This semi-annual review is documented and made available to the learner via MedHub.

For residents failing to progress, the program director develops a plan according to the Remediation, Disciplinary Action and Grievance policy.

International Residency Rotations Policy (new 2025-2026)

Last revised by program 6/20/2025

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements in addition to complying with the GME International Residency Rotations Policy. Per that policy, programs may have their own guidelines beyond the University of Colorado School of Medicine and GME requirements and procedures.

☒ The Internal Medicine program will consider elective international rotations with the following guidelines:

See 2025-2026 Coursebook for specific requirements needed for each international rotation opportunity.

Cancellations (outside of unforeseen medical issues) must be received at least 9 months in advance of the start date, to ensure that another learner can fill the spot with adequate time to complete all requirements. The resident's schedule will then be filled in with an ambulatory rotation of the program's choosing.

Beginning in 25-26, residents being considered for an international rotation will undergo a more intense application process, being reviewed by Global Health staff/faculty to ensure compatibility.

Leave Policy

Last revised by program 6/20/2025

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements in addition to complying with the current GME **Leave Policy**, and **ABIM policies.** **Details including, process and pay during an approved leave can be found in the GME Leave Policy.**

Jury Duty

If summoned during 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 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.

Parental/Medical Leave Policy

The Internal Medicine Program is committed to supporting residents who are growing their families by providing a fair and structured parental leave policy. This policy ensures compliance with Accreditation Council for Graduate Medical Education (ACGME) requirements, American Board of Internal Medicine (ABIM) requirements, and institutional policies while promoting resident well-being and professional development.

Eligibility

1. All residents in the Internal Medicine Program, regardless of gender, are eligible for parental leave following the birth, adoption, or foster placement of a child.
2. Parental leave is available to both birthing and non-birthing parents, including those with legal guardianship, adoption, or surrogacy arrangements.

Leave Duration and Structure

1. We will meet with any resident interested in parental leave to discuss leave options and to determine the best plan based on individual preferences, taking into account regulations put forth by both ACGME and the ABIM which include:
   a. Maximum of 3 non-clinical rotations during residency training (excluding sick and vacation time)
   b. Maximum of 140 days away from training prior to required extension of training

   i. This includes 4 weeks of vacation and educational leave per year (84 days), allowing for 56 additional sick days/days away from training total over a 3-year period
c. Residents are entitled to a minimum of **six weeks of paid medical/parental leave** per ACGME and institutional guidelines. Residents can use FAMLI leave which will use a portion of available vacation and sick time to supplement 4 weeks of vacation and 2 weeks of sick time per year.
d. Benefits will be fully covered during this time
e. All birthing or primary child caretaker parents are eligible for an additional non-clinical rotations (AMBOSS or scholarly activity). Moonlighting is NOT allowed during leave or either parental support rotation options.
f. A combination of leave and non-clinical rotation time is allowed

2. Scheduling of leave should be planned in consultation with **Senior APD Dr. Suddarth and Nicole Canterbury-Passoth,** with approval from **Program Director,** to ensure appropriate coverage and minimize disruption to clinical services.

Benefits and Support

1. Residents will maintain their **health insurance and benefits** during fully paid and partial paid parental leave through FAMLI.
2. Mental and physical health resources will be offered including options for ob/gyn care during pregnancy. The residency will help ensure the resident is able to make any care appointments before and after delivery.
3. Prior to delivery, birthing parents will not be assigned to any overnight shifts to minimize stress during the third trimester. Jeopardy shifts will not be assigned during the third trimester.
4. Resources will be provided to help with identification of childcare options.
5. Lactation accommodations, including designated spaces and break time for pumping, will be provided at each hospital site.
6. Connections to mental health resources and peer support will be made available to assist residents during their transition into parenthood.
7. The program acknowledges the potential impact on infant and child illnesses on resident training and will do its best to accommodate scheduling adjustments to minimize impact on training. We will ensure the resident understands their options with time away from training and available sick time in order to graduate on time or extend residency in some cases.

Requesting Parental Leave

1. Residents must notify the **Senior APD, Katie Suddarth,** as early as possible (preferably at least **three months in advance**) to facilitate scheduling and ensure smooth transitions in coverage.

2. Residents are encouraged to meet with Debra.J.Johnson@cuanschutz.edu in **Human Resources** to review their leave options, including the Family and Medical Leave Act (FMLA) and any state-specific parental leave policies.

Non-Retaliation and Non-Discrimination

1. No resident will face discrimination, retaliation, or negative academic consequences for utilizing parental leave.
2. The program is committed to fostering a culture that supports residents expanding their families during training.

Fertility Support

1. Fertility treatments are available in some situations through the CU resident insurance plan. For any residents interested in seeking fertility treatments including egg freezing and fertility preservation, the program will ensure protected time for residents to attend any appointments or procedures as part of that process.
2. For further inquiries regarding parental leave, residents should contact the **Program Director** or the **GME Office**.

Sick Leave

1. Any resident who takes more than 7 days of sick leave in an academic year will be reviewed in further detail on the Clinical Competency Committee. Per ABIM Policy, training must be extended to make up for any absences exceeding 105 total days away from training (35 days per year) which includes vacation and sick leave unless a special exemption is requested. Residents must be in good standing as determined by the Clinical Competency Committee and Program Director for exemption to be requested. The Clinical Competency Committee will ensure that the resident is meeting expectations and will also provide residents with greater than 7 days of sick leave per year with additional resources and support as indicated.
2. For one to two days of sick time per 4-week clinical rotation, the residency program will not ask for further information as to the reason for the request for sick time. At 3 days of continuous leave or if a resident calls out sick more than 3 days during a single 4-week rotation, the program will ask for information about the reasons for leave to provide appropriate resources and may request documentation from medical provider at that time.

3. Training must be extended under all circumstances for absences exceeding 140 days (including vacation time, sick leave and parental leave).

Contact your Chief Resident, Kendra.Lewis@cuanschutz.edu and appropriate rotation supervisors for episodes of acute illness.

For more prolonged absence, residents should contact Senior Associate Program Director, Dr. Kathleen.Suddarth@cuanschutz.edu and Jennifer.Weber@cuanschutz.edu as far in advance as possible to discuss any anticipated absences due to personal or family health issues.

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 weekdays.

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. **Residents will be permitted to miss a maximum of 4 Wednesdays throughout the year, across all vacation time. This is regardless of whether WES is held on the Wednesdays being missed or not. Residents must attend WES in person, otherwise it will be counted as a vacation day.**

You must take at least 1 but no more than 2 of these vacation weeks during your clinic-heavy blocks. You must take at least 2 but up to 4 vacation weeks during elective-heavy blocks unless permission has been given from the Housestaff Office for another arrangement. The winter break week does not count as a clinic-heavy block.

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. You may make changes to these originally scheduled vacation weeks throughout the year with sufficient notice (as outlined below).

Academic presentations and conference attendance during all electives count toward your vacation days (one of your vacation weeks is reserved for this purpose). As mentioned above, you should schedule all 4 of your weeks prior to

the start of the academic year, however if you hope or plan to attend a conference, please place your 4th week toward the end of the academic year so that you can pull days from it to cover conference attendance.

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 Jennifer.Weber@cuanschutz.edu 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 cannot be carried over to the next academic year.

Vacation during Research:

Travel (both personal and conference-related) during Research rotations is allowed (without needing to utilize vacation time) on days that you are **not** scheduled for jeopardy, WES and/or your continuity clinic.

If you wish to ensure that a week is completely protected from these requirements, you will need to use vacation time which is expected to be taken in **seven concurrent days**. You are permitted to split up **one** of your four weeks of vacation for the year for the purpose of a major life event or a conference. If there is a reason to not take your vacation days during Research concurrently (and you have not already split one of your weeks), please discuss this with Kendra.Lewis@CUAnschutz.edu.

Basecamp:

Basecamp runs from the last week of June through the first week of July. Basecamp **is not** vacation eligible except through special request.

Winter Break:

Winter Break encompasses the 2 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. Priority is given to R3s when assigning vacation weeks over winter break. You will be on wards/inpatient the opposite week.

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

New Vacation Requests & Vacation Change Requests:

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

Outside of the initial vacation solicitations, new requests or change requests throughout the year will follow this process:

1. Requests affecting a date falling within the next 60 days or less will be denied. If you have a **previously unforeseen and urgent need** please email your clinic director (re: add back) and Kendra.Lewis@CUAnschutz.edu directly.

2. Requests affecting a date falling within the next 61-120 days during elective will only be approved if the elective can accommodate the absence and your clinic is amenable to adjusting your add-back, and ITE or Step 3 are not impacted. Requests affecting a clinic block will be subject to clinic director approval. These requests should be submitted via the Formstack https://ucdenverdata.formstack.com/workflows/vacation_request

3. Requests affecting a date falling within the next 121+ days should be submitted via the Formstack https://ucdenverdata.formstack.com/workflows/vacation_request

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). Any jeopardy changes need to be requested via the Swap Request Form.

Half Day Absences

Illness:

1. If you have seen patients before departing, this will not count as a sick day and no makeup activities will be required. Email the rotation director or chief resident (if inpatient).
2. If you have not seen patients before departing, this will count as a full sick day. Email the rotation director, chief resident (if inpatient) and Nicole.CanterburyPassoth@cuanschutz.edu

3. In general, we assume if you miss a morning due to illness you will be ill in the afternoon as well, including for WES, POCUS, and ambulatory didactics. Please email Nicole, Jefferson and Dr. Urra for WES, Matt and POCUS faculty lead for POCUS, and your continuity clinic director and Jefferson for ambulatory didactics.

Other absences:
We recognize there are times you may need to miss a half day for different reasons. In general, we expect you to utilize half days that are open including PG&D and open SD half days, but we recognize this will not always be possible. These absences will be tracked by the program, we expect this will be a rare occurrence.

This includes appointments that you attempted but were unable to schedule for your PG&D half day, voluntary teaching activities, local conference presentations, travel to conferences, and research mentor meeting that you cannot schedule at a different time. For all non-illness related half-day absences, residents will be required to use vacation, move task coverage time, or complete AMBOSS questions.

1. Absences related to IMRP recruitment activities or semi-annual meetings with your APD do not require make-up.
2. Absences during PG&D half day or non-POCUS SD half day do not require vacation or AMBOSS questions.
3. Absences during inpatient rotations: the expectation is you are still completing the work of the day and have a sound transition/coverage plan for the time you will be unavailable.
4. You are expected to communicate about anticipated absences ahead of time and urgent unexpected absences (i.e. an appointment slot opens up that morning) when you become aware of them. If you do not provide appropriate notification, you will be required to do the AMBOSS questions and receive a missed deadline.
    a. WES: email Dr. Urra and Jefferson
    b. Clinic QI/ambulatory: email clinic director and Jefferson
    c. Task Coverage: email the clinic director to see if this task coverage work could be shifted to another time in the same clinic week. If not possible, will do AMBOSS questions and the resident should email the clinic director and Jefferson
    d. POCUS: email Matt and your POCUS faculty lead
    e. In general for patient-facing half days in clinic or RAC, you will be expected to take a full vacation day. <u>We are not able to track vacation half days</u>. If you need to schedule an appointment during a portion

patient-facing half day then you will be expected to complete AMBOSS questions for the portion of patient facing time missed.

AMBOSS questions will be due the Monday after the half day is missed. Failure to complete the required questions by this due date will result in a missed deadline.

1. 1 hour missed = 15 questions, 2 hours missed = 30 questions, 3 hours missed = 45 questions, 4 hours missed = 60 questions
2. You will create the quiz or complete the appropriate number of questions in your question bank as opposed to having the quiz assigned to allow you to focus on relevant material to the rotation you are on or an area you want improve.

See above for how to request and utilize a full vacation day.

Leave for Fellowship and Job Interviews:

You may miss up to 10 full days (20 half days) total for fellowship and job-related travel/interviewing without needing to make up any time. This is in addition to your annual vacation days.

1. **You must contact the residency program when you accept and schedule any interview** (for fellowship or job).
2. **Please fill 2025 2026 Fellowship/Job Leave within 24 hours of accepting an interview** so we can properly record your absence.
3. If you need to **change an interview date**, please email Kendra.Lewis@cuanschutz.edu and IMRPSchedule@cuanschutz.edu
4. **You are responsible for communicating your absences to your rotations** –Please alert them as soon as you schedule an interview.
   a. **Clinic**: continuity clinic director
   b. **RAC:** RAC chief resident
   c. **Electives, ER:** rotation director.
   d. **Inpatient:** fill out the form above.

Specific rotation considerations:

1. **Clinic** – as patients are scheduled 60 days in advance, your clinic will likely need to cancel them during your absence. Please schedule during a non-patient facing half day or during an elective as much as possible.
2. **RAC –** as patient access will be impacted, please try to schedule during an elective when possible. 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.

3. **ER:** this is a graduation requirement, therefore you need to attend at least 50% of your shifts that block. You will also 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.
4. **Inpatient:** please try to schedule during an ambulatory block, but if not possible, fill out the formstack above as soon as possible so we can plan for coverage. We do have residents on unassigned wards for this coverage purpose.

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 workdays that you can miss.

1. In general, more than 10 full days will not be granted without making up that time, but if there are extenuating circumstances, please contact Dr. Limes to discuss the potential approval of additional days.
2. If you travel for a fellowship or job interview or have a virtual interview on a weekend that you were otherwise not scheduled to work, you do not owe the program any time or make-up activities.
3. We track by half days, therefore, if you will only miss a half day for an interview, it will only be counted as a half-day. In other words, you can miss 20 half days.
4. The 20 half days may be used towards attendance at a formal Second Look Event, but not for informal visits to programs/cities.

Requesting Jeopardy Protection (interns only):

A survey will be sent out in May whereupon you can request jeopardy protection for the first four blocks of the year. Another survey will be sent out in June to capture jeopardy requests affecting the 5th block, 6th block, and the Winter Weeks. In September a final survey will be sent out whereupon you can request jeopardy protection affecting January - June.

Requesting Day off of Ward/Required Rotation:

As a program, we do our best to support important life obligations and events for all our trainees. If you have any important life events, religious holidays or obligations that you would like to participate in, you will have 3 opportunities to submit these requests so that we can attempt to align your days off with these

important events. A survey will be sent out in May, encompassing the first four blocks of the year, whereupon you can that your day(s) off during an inpatient rotation fall on certain dates. Another survey will be sent out in June to capture these requests affecting the 5th block, 6th block, and the Winter Weeks. In September a final survey will be sent out whereupon you can submit requests affecting January - June.

Coverage Swaps:

Guidelines for Coverage Swaps:

1. The coverage swaps system can be used by residents for shorter absences related to personal or professional reasons.
2. As the resident on inpatient (the one needing coverage) you can arrange for no more than one coverage swap per rotation.
3. You can participate in a maximum of three reciprocal coverage swaps per year.
4. The coverage can be for 1, 2, or 3 days.

Guidelines for covering someone else:

1. Residents are not permitted to participate in coverage swaps that necessitate they miss patient-facing time continuity clinic half days.
2. You are not allowed to miss more than 3 days of an elective or geriatrics to cover someone else.
3. Residents ARE permitted to participate in coverage swaps that necessitate they miss non-patient facing time in continuity clinic (QI, SD, Task Coverage).
4. Residents are permitted to miss subspecialty clinic for coverage swaps
5. Residents are permitted to miss Geriatrics for coverage swaps.
6. You are allowed to miss RAC for one day to cover for an educational experience (i.e. conference) for another resident.
7. 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.
8. You cannot violate duty hours to cover a shift for someone else.
9. You cannot cover someone when you are on Jeopardy.
10. Ophtho prelims may not miss time from Ophtho rotations to provide coverage for someone else.
11. Swaps involving prelims may require approval from the parent program (i.e. Neuro or Ophtho). Please allow additional approval time for these requests.

Rules for requesting coverage from a co-resident:

1. 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.

2. You will not be "charged" vacation days for a coverage swap.

Approval Rules:

1. Must be submitted to the Swap Request Form https://forms.office.com/Pages/ResponsePage.aspx?id=yjczVhelGkKq4BqltBT9fwYRWCUKyJ1IlHYHytaDo4RUOVk0VUlFQ0NENkIwTEROQjlYTkdIMFZYUiQlQCN0PWcu and will be subject to approval by both the chief resident(s) at the affected sites and the admin office.
2. Must be arranged at least 3 months in advance.
3. If you need to request an urgent swap (emergent or unforeseen) that occurs in less than 90 days, please submit the form AND email your site chief and Nicole Canterbury-Passoth for special consideration. **Please be aware that requests falling within less than 90 days that are not of an emergent or unforeseen nature will not be approved.**
4. Requests must honor all swap rules as outlined on the Swap Request Form.

Full or Partial Rotation Swaps:

We have been intentional about the inpatient clinical experiences that we feel every intern and resident should have to be successful in their future careers. Therefore, the following rules apply to full or partial rotation swaps:

1. All interns are required to do a minimum of 4 weeks of ICU
2. All upper levels are required to do a minimum 4 weeks of ICU (preferably during R2 year, on occasion for special circumstances, this will be during R3 year)
3. All upper levels are required to do a minimum of 2 weeks of cardiology
4. Categorical residents are expected to do 4 weeks of cardiology

In order to minimize disruptions to team continuity given impact on both patient care and the learning environment as well as logistical challenges aligning call schedules, only the following rotations are eligible for 2-week split rotations:

1. Team X
2. ACE
3. VA Swing/Nights/ICU
4. The following rotations are NOT eligible for 2-week split rotations unless originally scheduled as a 2-week split rotation
5. VA Wards
6. U Wards
7. Cardiology (unless part of the Cards/ID rotation)
8. U MICU
9. Hepatology
10. CHF
11. DH Wards
12. DH ICU

Post-Call During Winter Weeks:
Residents who are post-call on the first day of their winter week vacation will be given that vacation day back by having the option to schedule it during elective (i.e. a non-continuity clinic vacation-eligible ambulatory block) on a day they do not have add back (the vacation day cannot impact patient-facing time in continuity clinic).

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 from 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.

Moonlighting Policy

Last revised by program 6/20/2025

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements.

In addition to complying with the GME **Moonlighting Policy**, and the **Moonlighting Approval Form** (found in MedHub à GME Resources and Documents à Finance Forms.), the Internal Medicine program recognizes that moonlighting is not an activity associated with part of the formal educational experience; thus, residents are **not** allowed to participate in moonlighting activities. This only applies to Chief Residents.

Residents, See Additional Pay for Additional Work Section for details.

Physician Well-Being & Impairment Policy

Last revised by program 6/20/2025

Internal Medicine Program

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements in addition to complying with the **GME Physician Well-Being & Impairment Policy**. Additional wellness resources are available on the CU GME Wellness webpages.

Residents/fellows 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.

Self-screening tools for burnout, depression, and substance use disorders are available in MedHub and the GME website. 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 or DIO.

Any concerns about work intensity, work compression, or workplace safety should be brought to the attention of the program director.

The University of Colorado Internal Medicine Program's policies and procedures are designed to improve trainee well-being and morale.

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

1. 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.
2. Wellness Curriculum: All interns participate in 4 sessions of wellness training as part of the More than Medicine longitudinal curriculum. All second and third years also participate in a More than Medicine workshop.
3. Wellness Committee. All residents are invited to sit on our APD and chief resident-led Wellness Committee. The committee is in place at the request of the Program Director, has faculty oversight and is charged with supporting residents in leading wellbeing initiatives for the program.
4. 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.
5. 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.
6. Faculty Confidential Advisors: The Internal Medicine 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.

7. 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:

1. 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
2. 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.
3. Creation of a More than Medicine curriculum that is delivered through all years of training in different formats.
4. 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.

Residents/fellows 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/fellows 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.

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 6-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 and the GME website. 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, or DIO 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) can also be contacted.

Any concerns about work intensity, work compression, or workplace safety should be brought to the attention of the program director.

The program ensures coverage and continuity of patient care, consistent with the program's Transition of Care policies and procedures in the event that a resident may be unable to perform their patient care responsibilities due to due to reasons such as fatigue, illness, family emergency, medical, parental, or caregiver leave 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.

Professionalism Policy

Last revised by program 6/20/2025

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements in addition to complying with the **GME Professionalism Policy** and provides a professional, equitable, respectful, and civil environment that is psychologically safe and free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. Residents and faculty are educated concerning the professional and ethical responsibilities of physicians and are provided with a confidential process for reporting, investigating, and addressing concerns around unprofessionalism.

The program director provides a culture of professionalism that supports patient safety and personal responsibility. Residents/Fellows 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:

1. without excessive reliance on residents to fulfill non-physician obligations
2. by ensuring manageable patient care responsibilities, and
3. through efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships.

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 can 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.

The program has instituted a Safe Learning Environment Committee which reviews faculty professionalism lapses and determines next steps according to our program policy in conjunction with Department of Medicine leadership. We have multiple avenues for residents to report professionalism issues including anonymous and confidential faculty evaluations; rotation evaluations; fully anonymous reporting portal on our website; direct reports to chief residents, associate program directors, or the program director; or direct reports to faculty or resident confidential liaisons.

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 the Program Director as well.

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

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

The Internal Medicine 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**' can be found on the IMRP Teams Resident Resources, Roadmaps + Deadlines.

2nd miss: You will receive an email noting the missed deadline. Your Associate Program Director (APD) will be notified via email as well. You will be offered the opportunity to speak to your APD if you would like.

3rd miss: You will receive an email noting the missed deadline. We will require that you and your APD meet to discuss a plan to prevent further missed deadlines.

4th miss: You will receive an email noting the missed deadline. We will require that you meet with your Associate Program Director to discuss the residency requirements, reflect on why the previous plan did not work, and come up with a new plan to prevent further missed deadlines. You will be required to use your personal time during clinic blocks on Friday afternoons to complete your missed deadlines until the requirement(s) are completed. You will be required to be physically present at the Housestaff office to complete this work. and will be required to miss at least one personal half day.

5th miss: You will receive an email noting the missed deadline. We will require you meet with the Program Director for all 5th missed deadlines. You will no longer be allowed moonlight (additional pay for additional work). You will miss all personal time half days on Friday afternoons for your next clinic block to complete missed deadlines. You will have to be physically present at the housestaff office during these times. You will complete additional AMBOSS questions during the remainder of that time after you complete your missed deadlines.

6th miss: You will receive an email noting the missed deadline. We will require you meet with your APD and the Program Director together, with an option to meet with leadership from the GME office. All residents with 6 missed deadlines will be brought to Clinical Competency Committee (CCC) for review for ACGME Milestone PROF-2 ("Accepts responsibility and follows through on tasks."). You will not be allowed personal time ½ days during clinic blocks or moonlighting privileges until it is decided that you are on track per CCC review.

7th miss: You will receive an email noting the missed deadline. We require that you meet with your APD and the Program Director together, with an option to meet with leadership from the GME office. Clinical Competency Committee review and Focused Review can be assumed. If you are placed on Focused Review, it is not a part of your Permanent training file. You will continue to be unable to moonlight and use personal time ½ days until it is decided by the Clinical Competency Committee that you are off Focused Review and on track.

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 certain responsibilities with it.

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 Committee

Last revised by program 6/20/2025

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.

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. Julia Limes (Program Director)
- Dr. Julia Bast (Chief Resident)
- Dr. Kathryn Berman (Clinic Director, Westside)
- Dr. Erin Bredenberg (Core Faculty)
- Dr. Elizabeth Breitbach (Assistant Program Director)
- Dr. Ellen Brinza (Chief Resident)
- Dr. Joseph Burke (Associate Program Director)
- Ms. Nicole Canterbury Passoth (Asst Program Administrator)
- Dr. Michael Castellarin (Clinic Director, VA)
- Ms. Elle Contreras (Recruitment Coordinator)
- Dr. Brittany Denzer (Chief Resident)
- Dr. Minh Do (Chief Resident)
- Dr. Caitlin Dietsche (Core Faculty)
- Ms. Anna Drum-Oden, N.P. (Assistant Clinic Director, VA)
- Dr. Brandon Fainstad (Core Faculty)
- Dr. Tyra Fainstad (Clinic Director, Lowry)
- Dr. Hoda Farajpourbakhtiari (Assistant Program Director CORE)
- Dr. Michelle Fleshner (Core Faculty)
- Dr. Daniel Gergen (Assistant Program Director)
- Dr. Emily Gottenborg (Associate Program Director; Director, Hospital Track)
- Dr. Reem Hanna (Core Faculty)
- Dr. Christine Haynes (Assistant Program Director, Primary Care)
- Dr. Daniel Heppe (Associate Program Director)
- Dr. Andi Hudler (Associate Program Director)
- Dr. Jason John (Core Faculty)
- Dr. Juan Lessing (Core Faculty)
- Dr. Jia Liu (Core Faculty)
- Dr. Emily Lowe (Chief Resident)
- Dr. Timothy McGinnis (Chief Resident)
- Dr. Carolina Ortiz-Lopez (Core Faculty)
- Dr. Anandi Ramaswami (Clinic Director, Sloan's Lake)
- Dr. Samuel Porter (Core Faculty)
- Dr. Gavi Roda (Chief Resident)
- Dr. Yasmin Sacro (Program Director, Primary Care)
- Dr. Sneha Shah (Core Faculty)

- Dr. Joshua Smith (Associate Program Director)
- Dr. Nicole Soiseth (Clinic Director, Webb)
- Dr. Karen Stenehjem (Associate Program Director)
- Dr. Kathleen Suddarth (Senior Associate Program Director)
- Dr. Benjamin Trefilek (Clinic Director)
- Dr. Jackson Turbyfill (Core Faculty)
- Dr. Manuel Urra (Assistant Program Director)
- Mr. Jefferson Velasco (Evaluation and Curriculum Coordinator)
- Ms. Jennifer Weber (Program Administrator)
- Dr. Kelly White (Clinic Director, Anschutz Clinic)
- Dr. Noelle Northcutt (Core Faculty)
- Dr. Julie Venci (Med/Peds Program Director)

PEC Responsibilities include, but are not limited to:

Acting as an advisor to the program director through

1. Program oversight;
2. Review of the program's self-determined goals and progress toward meeting them;
3. Guiding ongoing program improvement, including development of new goals, based upon outcomes; and
4. 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:

1. Outcomes from prior Annual Program Evaluations
2. Aggregate resident and faculty written evaluations of the program.
3. Other relevant data, such as:
    a. Curriculum
    b. ACGME letters of notification, including citations, Areas for Improvement, and comments
    c. Quality and safety of patient care
    d. Aggregate resident and faculty well-being; recruitment and retention; workforce diversity, including graduate medical education staff and other relevant academic community members; engagement in quality improvement and patient safety; and scholarly activity.
    e. ACGME Resident and Faculty Survey results
    f. Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance
    g. Aggregate faculty evaluation and 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 8 times per year (2-3 times per group, split up by block and class) with some of the meetings addressing rotation specific issues with the others dedicated to residency-wide issues (WES, curriculum, noon conferences, etc.). There are 3-4 resident RPEC leaders for each class and block (i.e. A block R2s, B block R2s, A block R3s, etc.) and all residents participate. The program director or a faculty representative are present to introduce the background of the topic and answer any questions and then they leave to facilitate open discussion. The program director and relevant faculty then meet with the RPEC leaders to review feedback and determine next steps.

Quality Improvement/Patient Safety Policy

Last revised by program 6/20/2025

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements 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.

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 several 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 rotate.

Supervision Policy

Last revised by program 6/20/2025

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements in addition to complying with the **GME Supervision Policy** and the **GME Residents Performing Telemedicine Policy.**

Program Supervision Overview

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 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 always available 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 (pended) and may contact patients as they normally would during clinic (with documentation of all calls which are to be cc'd to attendings) knowing that attendings are immediately available by phone, providing indirect supervision with direct supervision available.

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

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

Residents are monitored and assessed regularly by the faculty and program director regarding their abilities and progressive responsibilities in the care of patients based on the clinical and technical abilities and skills of the residents. Faculty formally evaluate resident performance in certain core competencies at the completion of each rotation. The Clinical Competence Committee meets at least twice each year to review overall resident performance and assist the program director in making decisions regarding progression through the program. Residents must know the limits of their scope of authority, and the circumstances under which they are permitted to act with conditional independence.

Senior residents serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual residents on all inpatients. An attending personally sees every patient to finalize the care plan and is available by phone or with physical presence at all times.

Definitions of Supervision (Direct, Indirect, and Oversight)

The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.

Direct Supervision:
The supervising physician is physically present with the resident during the key portions of the patient interaction.

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.

1. PGY-1 residents must initially be supervised directly, only as described in the above definition.
2. 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.

1. The program must define when physical presence of a supervising physician is required.
2. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
    a. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.
    b. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.
    c. Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

3. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).
    a. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.
4. Faculty supervision assignments must be 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.

INTERNAL MEDICINE
HOUSESTAFF PROCEDURE SUPERVISION

Levels of Supervision by Level of Training and Ability
As required by ACGME, the program has identified below when the *physical presence* of a supervising physician is required.

PATIENT MANAGEMENT	Direct	Indirect	Oversight
Admit patients to service	PGY 1	PGY 2 and above	DH MICU nights rotation – CCC determines if ready for rotation
Complete H & P	PGY 1	PGY 2 and above	DH MICU nights rotation – CCC determines if ready for rotation
Evaluate, Diagnose, Treat, and Manage	PGY 1	PGY 2 and above	DH MICU nights rotation – CCC determines if ready for rotation
Make referrals and request consultations	PGY 1	PGY 2 and above	DH MICU nights rotation – CCC determines if ready for rotation
Order Diagnostic Studies and Procedures	PGY 1	PGY 2 and above	DH MICU nights rotation – CCC determines if ready for rotation
Order Medications	PGY 1	PGY 2 and above	DH MICU nights rotation – CCC determines if ready for rotation

Medical Management of post-surgical patients using good medical judgment for appropriate consultation	PGY 1	PGY 2 and above	DH MICU nights rotation – CCC determines if ready for rotation
Complete Continuity Clinic visit	1st 6 months PGY1	PGY1 month 7 and above, AND CC director approval for indirect	n/a
Complete Specialty Clinic visit	Entire time in training	n/a	n/a
SEDATION			
Local Anesthesia	Included in below procedural guidance		
GENERAL INTERNAL MEDICINE PROCEDURES			
Abscess drainage	Any PGY who has not met criteria for indirect	>5 procedures performed	n/a
ACLS	PGY 1	PGY 2 and above	PGY 2 and above
Anoscopy	Any PGY who has not met criteria for indirect	> 5 procedures performed	n/a
Arterial Blood Gas	Any PGY who has not met criteria for indirect	>10 total procedures performed AND > 2 passing assessments	DH MICU nights rotation – CCC determines if ready for rotation
Arterial Line Placement	Any PGY who has not met criteria for indirect	>10 total procedures performed AND > 2 passing assessments	DH MICU nights rotation – CCC determines if ready for rotation
Arthrocentesis	Any PGY who has not met criteria for indirect	>5 procedures performed AND > 2	DH MICU nights rotation – CCC determines if

		passing assessments	ready for rotation
Aspirations and injections, joint or bursa	Any PGY who has not met criteria for indirect	>5 procedures performed AND > 2 passing assessments	DH MICU nights rotation – CCC determines if ready for rotation
Bronchoscopy	Entire time in training	n/a	n/a
Bone marrow aspiration or needle biopsy	Entire time in training	n/a	n/a
Cardioversion, electives	Entire time in training	n/a	n/a
Central venous catheterization	Any PGY who has not met criteria for indirect	>10 total procedures performed AND > 2 passing assessments	DH MICU nights rotation – CCC determines if ready for rotation
ECG interpretation	PGY 1	PGY 2 and above	DH MICU nights
Exercise treadmill test	Entire time in training	n/a	n/a
ETT with thallium	Entire time in training	n/a	n/a
Excisions/Skin biopsy	Any PGY who has not met criteria for indirect	>5 procedures performed AND > 2 passing assessments	DH MICU nights rotation – CCC determines if ready for rotation
Lumbar puncture	Any PGY who has not met criteria for indirect	>10 total procedures performed AND > 2 passing assessments	DH MICU nights rotation – CCC determines if ready for rotation
Pacemaker insertion, transvenous; temporary	Entire time in training	n/a	n/a
Pap smear	Any PGY who has not met criteria for indirect	>5 procedures performed	n/a
Paracentesis	Any PGY who has not	>10 total procedures	DH MICU nights rotation

	met criteria for indirect	performed AND > 2 passing assessments	– CCC determines if ready for rotation
Pericardiocentesis, emergent	Entire time in training	n/a	n/a
Suturing	Entire time in training	n/a	n/a
Thoracentesis	Any PGY who has not met criteria for indirect	>10 total procedures performed AND > 2 passing assessments	DH MICU nights rotation – CCC determines if ready for rotation
Tracheal intubation, emergent	Entire time in training	n/a	n/a
Tube thoracostomy	Entire time in training	n/a	n/a
Peripheral IV placement	Any PGY who has not met criteria for indirect	>10 total procedures performed AND > 2 passing assessments	DH MICU nights rotation – CCC determines if ready for rotation

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

More detail regarding procedures:

	High Complexity Simulation curriculum	Low Complexity Simulation curriculum	Low Complexity
	Arterial line CVC insertion Lumbar puncture Paracentesis Thoracentesis	Knee inj Sub-acromial inj Skin biopsy	All others (e.g., IUD)
Total performed	> 10	> 5	5
Assessments performed	> 5	> 3	
Passing assessments Requires all 3: Checklist = all steps independently GSA = Proficient Entrustment = No-direct supervision	> 2	> 2	
Annual requirement to maintain privileges	1 passing assessment	1 passing assessment	

Addendum: Moderate Sedation at University of Colorado Hospital

Do Residents/Residents perform Moderate Sedation at UCH?	**YES ☐**	**NO ☒**

Transitions of Care (Structured Hand-off Process) Policy

Last revised by program 6/20/2025

The Internal Medicine Program complies with the ACGME Common and *specialty-specific* Requirements in addition to complying with the GME **Transitions of Care (Structured Patient Hand-off) Policy.**

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

Time/Place
The location should minimize distractions/interruptions and allow access to needed resources (e.g., appropriate information systems). The handoff process must allow the receiving physician to ask questions; thus, verbal handoffs are required as well as written among caregivers assuming primary care.

Transitions of Service
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. Residents/Fellows are accountable to additional requirements as specified in each institution's Medical Staff Policies/Rules/Regulations.

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 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

☒ 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, COMLEX, & LMCC Examinations

Last revised by program 6/20/2025

The Internal Medicine Program complies with the GME **USMLE, COMLEX, & LLMC Examinations Policy**.

USMLE Step 3 must be completed in PGY1 year.

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 in the Housestaff Office. Details for scheduling USMLE are on their website.

Medical Student Learning Objectives

Last revised by program 6/20/2025

Medicine Acting Internship

MEDICAL KNOWLEDGE AND CLINICAL CARE:

1. Take a complete history for core IM symptoms and illnesses, which include chest pain, dyspnea, edema, hypoxia, altered mental status, jaundice, anemia, COPD, CAD, CHF, GI bleed, DVT/PE, liver disease, pneumonia, renal failure, substance use disorders, and cancer.
2. Correctly perform a comprehensive and/or focused physical examination as indicated by the presenting complaint.
3. Accurately develop a differential diagnosis for, an appropriate assessment of, and a clinically appropriate diagnostic and treatment plan for the core signs, symptoms, and clinical issues described above.
4. Interpret the results of the following diagnostic tests and identify appropriate indications for ordering them:
   a. Basic chemistries including renal function and hepatic function studies
   b. ABG
   c. Cardiac Enzymes
   d. Cultures/Gram Stains
   e. EKG
   f. Chest X-ray, basic interpretation of Chest and Abdominal CT's

5. Care for up to 2/3 of the patient load of a typical intern on an inpatient service. The average number of patients an acting intern is expected to care for is between 5-6 patients daily by the latter half of the rotation.
6. Admit new patients when on-call
7. Provide cross coverage on patients of other medical providers
8. Recognize a patient requiring urgent or emergent care and initiate evaluation and management
9. Enter orders in the electronic health record for co-signature by senior resident

COMMUNICATION:

1. Clearly convey medical information to professional colleagues (other physicians, students, nurses, case managers, social workers, pharmacists and other ancillary staff members).
2. Deliver complete and organized oral presentations daily that include updated prioritization of medical issues
3. Complete organized, accurate, and concise written documentation of patient encounters.
4. Give and receive handoffs during transitions of care
5. Effectively communicate clinical information and updates with patients and their families in a way that promotes shared decision-making
6. Deliver difficult news to patients and families and play an active role in goals of care discussions

PROFESSIONALISM:

1. Interact respectfully with ALL members of the health care team, consultants and fellow physician providers.
2. Demonstrate ethical behavior and core attributes of professionalism including reliability, willingness to ask for help/admit limits, integrity, duty, respect, honesty, and advocacy.
3. Care for a diverse patient population and deliver culturally-competent care

SYSTEMS-BASED PRACTICE:

1. Recognize the roles and contributions of interdisciplinary team members to patient care
2. Understand the principle of high-value care and demonstrate understanding of the appropriate use of medical resources.
3. Analyze the cause of medical errors that are secondary to system-related weaknesses.

PRACTICE-BASED IMPROVEMENT:

1. Seek out and incorporate feedback to improve performance and professional growth.
2. Foster a positive dynamic with the more junior medical student on the team by offering coaching and teaching to them where appropriate.

3. Apply evidence-based medicine and statistical concepts such as likelihood ratios to make appropriate and meaningful clinical decisions.