Policies for the Internal Medicine Residency Training Program

July 1, 2018 to June 30, 2019

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I. General Policy Statement

The residency program is designed to provide residents with an extensive experience in the art and science of medicine in order to achieve excellence in the diagnosis, care, and treatment of patients. To achieve this goal, residents agree to abide by certain policies and guidelines. In return, they are given a number of benefits and the training they need to be successful in their careers. The residency program follows all Graduate Medical Education Committee (GMEC) policies.

Below is a look at the policies and fair process procedures of the residency program.

II. Resident Supervision Policy

1. The Internal Medicine Program will supervise residents:
    a. to ensure the provision of safe and effective patient care
    b. to ensure that the educational needs of the residents are met
    c. to allow for progressive responsibility appropriate to the residents' level of education, competence and experience
    d. according to specific supervision requirements in the Internal Medicine Program Requirements
2. In compliance with the GMEC policy Resident Supervision (240), the following guidelines are followed for supervision of Internal Medicine residents:
    a. Qualified faculty directly or indirectly supervise all patient care at each participating site. Faculty schedules are structured so that adequate supervision, for the level of resident learner, is available at all times. Supervision is classified as "direct", meaning the attending is physically present, or "indirect", meaning the attending is immediately available by phone or other electronic means and able to be present if necessary.
    b. At night and other off-hours, residents are able to identify their supervisory faculty by viewing the on call schedule.

c. Rapid, reliable systems for communication with supervisory faculty are available via cell phones and pagers.
d. Attending faculty supervision is provided appropriate to the skill level of the residents on the service/rotations.
e. Residents have progressive responsibility according to their level of education, competence and experience.
f. Specific responsibilities for patient care are included in the written description of each service/rotation; this information is reviewed with the resident at the beginning of the rotation and is available at any time via New Innovations.
g. The following procedure is to address resident fatigue :
    a. The chief resident is contacted and arrangements are made for the backup resident to relieve the fatigued resident.
    b. The chief resident determines when the fatigued resident should return to the education program.
    c. The chief resident notifies the attending faculty about these arrangements.

III. Clinical Experience and Work Hours Policy (prior referenced as Duty Hours Policy)

The Baptist Health - UAMS Internal Medicine Residency Program is committed to compliance with the ACGME Clinical Experience and Education Work Hours guidelines and the GMEC policy Clinical Experience and Work Hours Policy (220). In accordance with the new common program requirements dated July 1, 2017, the following requirements apply to the Internal Medicine Residency Training Program. The Internal Medicine residency program is focused on creating an atmosphere that provides residents with educational and clinical experiences, as well as reasonable opportunities for rest and personal activities.

Clinical Experience and Education Work Hours are defined by all clinical and academic activities that are directly related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, transfer of patient care, time spent in-house during call activities, clinical work competed at home, and scheduled activities, such as conferences. Clinical Experience and Education Work Hours will also include all moonlighting activities as defined in the relevant section.

<u>Maximum Hours of Clinical Experience and Educational Work per Week:</u>

1. Internal Medicine residents may not work more than 80 hours per week, when averaged over a four-week period.
2. This includes all in-house clinical experiences, educational activities, and all clinical work completed at home.

<u>Mandatory Time Free of Clinical Experience and Education Work:</u>

1. Residents will have eight hours off between scheduled clinical work and education periods, and at least 14 hours free from clinical work and education after 24 hours of in house call.

2. Residents must be scheduled for a minimum of one day in seven free from clinical work and education, when averaged over four weeks. At-home call cannot be assigned on these free days.
3. There may be circumstances when residents choose to stay to care for their patients, or return to the hospital with fewer than eight hours free of clinical experience and education, but this must occur within the context of the 80-hour work week and one- day-off-in-seven requirements

Maximum Clinical Experience and Education Work Period Length:

1. Residents must not be scheduled for Clinical Experience and Educational work periods that exceed 24 hours of continuous clinical assignments.
    a. Up to an additional 4 hours of time may be used for activities that are related to patient safety including effective transitions of care, and/or resident education.
        i. Residents cannot be assigned to additional patient care responsibilities during this additional four hours.

Clinical Experience and Educational Work Hour Exceptions:

1. In rare circumstances, residents on their own initiative and after handing off all other responsibilities, may elect to remain or return to the clinical site in the following circumstances:
    a. To continue to provide care to a single severely ill or unstable patient
    b. To provide humanistic attention to the needs of a patient or family
    c. To attend unique educational events
    d. Continuity of care for patients
    e. A declared emergency or disaster, for which the residents are included in the disaster plan;
    f. Perform high profile, low frequency procedures necessary for competence in the field.
2. These additional hours of patient care or education must be counted toward the 80- hour weekly limit.
3. The program will not consider requests for exceptions to the 80-hour limit on the resident's work weeks.

In-House Night Float:

1. Night float rotations must occur within the context of the 80 hour and one-day-off-in- seven requirements.

Maximum In-House On-Call Frequency

1. Residents must not be scheduled more frequently than every third night, and cannot be averaged over a four-week period.

IV. Moonlighting Policy

1. Though the GMEC policy Resident Moonlighting (170) allows residents to moonlight, considering that the care of the patient and educational clinical duties are of the highest priority, Internal Medicine residents of all levels are not allowed to participate in internal or external moonlighting.

2. Residents will be subject to discipline up to and including dismissal from the program for engaging in moonlighting without written approval of the Program Director.

V. Addressing Resident Concerns Policy

1. In compliance with the GMEC policy Resident Grievances and Due Process (180), the resident should follow these guidelines to raise and resolve issues of concern in a confidential and protected manner:

2. If a resident has any concern, the following approach is recommended:
    a. A resident should discuss the concern with either the supervising-senior level resident or attending physician or the Chief Resident or the resident's assigned faculty advisor.
    b. If the above discussion does not resolve the concern, the resident should meet with the Program Director or his designee.
    c. If the issue is of such a nature that it cannot be discussed at the program level, or if the resident feels uncomfortable doing so, or the resident desires additional discussion, the resident should follow the following procedure:
        i. The resident contacts the Associate DIO and/or a peer selected representative of the Resident Council.
        ii. If the resident wishes assistance from the Resident Council , the following steps should be followed:
            1. The resident should contact at least two members of the Resident Council, one of which is to be a peer selected representative, to schedule a meeting to discuss the problem confidentially.
            2. The Resident Council members will meet with the resident and offer advice on how to resolve or handle the problem and if further steps are necessary. Based on the discussion and advice at this meeting, the resident may resolve the problem, and no further action is necessary.
            3. If the resident's problem cannot be resolved or is of such a nature that further information is needed, the Resident Council members should discuss the problem with the Associate DIO or a GMEC Representative.
3. The procedure for resolution will vary depending on the type of issue:
    a. For issues related to general work environment, the Associate DIO or Resident Council may discuss the issues and make recommendations for resolution through the GMEC.
    b. Issues related to disciplinary action will be addressed according to the due process procedure outlined in the GMEC policy Resident Grievances and Due Process (180).
    c. Should a resident wish to file an official grievance, the resident should refer to the GMEC policy Resident Grievances and Due Process (180).
4. Discussions and recommendations by the Resident Council and/or the GMEC are confidential to the extent authorized by law, and handled in a manner to protect the resident.

VI. Transitions of Care and Handoffs Policy

1. In compliance with the GMEC policy Transitions of Care (250), the following guidelines are followed for patient handoffs with Internal Medicine residents:
2. Patient handoffs on the inpatient services are performed face-to-face (or less desirably, by phone) and an electronic and/or type-written document is provided by the transferring team/physician to the receiving physician/team at the time of the handoff.

3. Careful, thorough, verbally communicated checkouts are required for all transitions of care. The attending physician on the team must engage in evaluation of resident handoff skills to the call or float team during the handoff process. If the attending physician is not immediately available during the handoff process, the covering team is expected to call the attending physician for concerns, questions and critical events.
    a. The residents are expected to use the SBAR framework at each transition or handoff as follows:

SITUATION	BACKGROUND	ASSESSMENT	RECOMMENDATION
Patient name	Recent procedures	Diagnosis	Next Actions
Medical record number	Changes in condition	Status	Anticipated procedures
Admitting physician	Changes in treatment	Level of acuity	Outstanding tasks
Overall situation	Current medication	Code status	Outstanding tests
	Current Status		Anticipated changes
	Current Vitals		
	Allergies		
	Recent lab tests		
QUIET PLACE Receiver asks questions, repeats handoff information Face-to-Face in a Quiet Place (PREFERRED). If face-to-face is unavailable, a phone call is the only other available handoff method			

4. Handoff education is provided on at least an annual basis as a component of the educational conference series; and issues related to this topic are reviewed routinely at M&M conferences and morning report.

VII. Clinical Competency Committee Policy

The Clinical Competency Committee (CCC) for the Residency Program serves in an advisory capacity to the Program Director on resident performance, promotion, and appropriate remediation and disciplinary decisions, if needed. The CCC also complies with the institution-specific policies and procedures of the Baptist Health-UAMS Graduate Medical Education Program Graduate Medical Education Committee (GMEC) as mandated by the ACGME, including the appropriate disciplinary and remediation procedures (e.g. the Resident Grievances and Due Process Policy).

Members of the Committee are chosen by the Program Director and include at least three members of the program faculty. In addition, the Program Director may serve as a member. The CCC meets on a semiannual basis as well as any ad hoc meetings to address pressing resident issues that cannot wait until the next regularly scheduled meeting.

The CCC is responsible for the following:

a. Reviewing all resident evaluations semiannually. These evaluations may include: resident self-evaluations, evaluations of residents on rotations, peer evaluations, 360 evaluations, chart reviews, and clinical skills evaluation. The CCC is cognizant that there is a learning curve in the Milestone mapping process for the faculty, the committee, and residents. There are dedicated teaching sessions for faculty on how to provide appropriate, consistent evaluations and feedback for residents. For residents, there are teaching sessions on
self-evaluation and performance improvement.

b. Reviewing participation in didactics, clinical and educational work duty hour compliance, scholarly activity, professionalism, procedure logs, simulation experiences, and any other program requirements.
c. Preparing and assuring the reporting of Milestone evaluations of each resident semiannually to the ACGME.
d. Advising the Program Director regarding resident progress, including promotion, remediation, and dismissal.
e. Preparing a report summarizing the CCC's recommendations and rationale from each meeting.
f. Advising the Program Evaluation Committee about any evaluation issues identified during CCC meetings.
g. Reviewing annually, with the Program Evaluation Committee, program-specific requirements to ensure compliance with all aspects of the CCC duties, responsibilities and reporting to the ACGME. This includes understanding and reviewing the specialty-specific Milestones, discussing and deciding best methods of assessment for the Milestones, identifying new evaluation tools, and reviewing the faculty mentor system.

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VIII. Program Evaluation Committee Policy

The Program Evaluation Committee (PEC) is designed to provide an overview and evaluation of the residency program on a continuous cycle throughout the year and meets on a semiannual basis. As chair of the PEC, the Program Director is responsible for appointing at least two other faculty members. Membership also consists of two residents from the program who are peer-selected to sit on the committee.

The PEC tasks include:

1. Reviewing and making recommendations for revisions of competency-based curriculum goals and objectives. The committee reviews the program goals and objectives, and the effectiveness with which they are achieved.
2. Reviewing the program annually using program evaluations completed by faculty, residents, and others.
3. Planning, developing, implementing and evaluating the educational activities of the program, including, but not limited to: the didactic program, resident simulation experience and clinic teaching at patient-side.

4. Addressing areas of non-compliance with ACGME Standards.
5. Reviewing and addressing any issues brought forth by any member of the program, hospital or outsider about ACGME compliance,
6. Reviewing any ACGME citations or areas for concern.
7. Developing plans of action to address and correct program issues utilizing the Annual Program Evaluation.

The PEC is also tasked with analyzing the program and producing a written Annual Program Evaluation (APE), which documents formal and systematic evaluation of the curriculum.

In this APE, the committee must monitor, track and report on the following areas:

1. Resident Performance
   a) Outcome assessment of the educational effectiveness of inpatient and ambulatory (outpatient) teaching
   b) Faculty Development
   c) Graduate Performance
      1. At least 80 percent of the program's graduates from a three-year period must take the specialty-specific Board exam
      2. At least 80 percent of the program's graduates from the past three years must pass the specialty-specific Board exam on the first attempt
   d) Scholarly Activity

2. Program Quality
   a) Reviewing the annual resident and faculty confidential evaluation of the program, and all other evaluation methods used to improve program quality
   b) Reviewing the ACGME annual resident and faculty surveys.

      i.

3. The APE must be submitted to the DIO for review for the Annual Institutional Review.