UNIVERSITY OF NEVADA, RENO
SCHOOL OF MEDICINE

INTERNAL MEDICINE RESIDENCY

RESIDENCY HANDBOOK

2018-2019

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I. INTRODUCTION

The three-year categorical residency training program in Internal Medicine at the University of Nevada, Reno School of Medicine is intended to provide the graduate with a strong educational and clinical experience that will prepare them for either practice in general internal medicine or to proceed to subspecialty training. Our curriculum is structured to cover the entire breadth of internal medicine with sufficient depth of subspecialty medicine for the practice of general internal medicine, or as preparation for a subspecialty fellowship. Much of the residents' time is spent on inpatient general internal medicine wards, critical care wards, and in ambulatory care clinics. In addition, all categorical residents receive training in all major subspecialties of internal medicine, as well as neurology, emergency medicine and night float. Exposure to non-internal medicine specialties is available through elective rotations and noon conference lectures. Other topics covered through didactic sessions include proper use of laboratory studies, medical ethics, cost effectiveness in medicine, medical informatics, risk management, critical assessment of the medical literature, patient handoffs billing and coding and nutrition. Several Modules in Ambulatory Care, Quality Improvement and Patient Safety are also provided.

The primary care track (PCT) residents will have more of their education focused on the ambulatory setting for specialty services in addition to the general medicine continuity clinics. The PCT residents will have the required inpatient experience and diverse medical education so fellowship could also be pursued.

We understand that some residents will wish to pursue careers in academic medicine, subspecialty internal medicine or specialties outside of internal medicine. Incorporated into the curriculum is some flexibility to help residents pursue their individual career goals and interests, including an opportunity to do either clinical or bench research.

We also understand that residents matriculating into our program come from diverse backgrounds and that their prior training, medical education, cultural and social background, ability and expectations may vary widely. If possible, we will develop an individualized curriculum for those residents who request it. Our preliminary interns have schedules closely matching those of their categorical colleagues. The preliminary interns do not do ambulatory clinics and are allowed time to do some focused electives.

The program highly values professionalism and there are several expectations in attendance, participation and completion of tasks that will be monitored.
II. CURRICULUM, EDUCATIONAL GOALS, SCHEDULE and LEAVE

The Curriculum for all core rotations is available in electronic format online at http://med.unr.edu/internal-medicine/residency/curriculum. Each curriculum includes contact information, schedules, a reading list and educational goals and objectives for that rotation. Some or all of the items on the reading list may be found in the curriculum binders in the program office but they are all also available online through the University of Nevada School of Medicine Savitt Medical Library website at https://library.unr.edu/Savitt. Residents are expected to review this information prior to starting rotations and contact faculty the week before to discuss specific didactic schedule. These online resources can be accessed from any internet-connected computer with your UNRMed ID and password.

The curriculum for the Primary Care track is available to download on the following site: http://med.unr.edu/internal-medicine/residency/curriculum. Goals and Objectives for each Skills Enhancement Clinic can be found on the UNRMed power desktop. Skills enhancement clinics are found at https://medremote.med.unr.edu/RDWeb/Pages/en-US/login.aspx To log in use NETID and email password then click on Med Desktops and download app to open the desktop. Go to remote desktop then click on IM North Residency Program. Select Primary care Track, then select skills enhancement Clinics. Locations and preceptors for the PC Track Skill Enhancement Clinics can be obtained by contacting: Jorge Pulido-Rubio (Program Coordinator) 327-5174.

Note: for inpatient rotations (ICU / Night Float / Ward Medicine), please refer to the above curriculum link and description under “Inpatient Medicine”.

Note: For PC Track trainees, all inpatient rotations will be 5 weeks in length, however PC Track residents will do only 4 weeks on inpatient blocks with the 5th week reserved for either assigned vacation times or emergency room rotations.

It is the intent of the department to place resident education above service obligations. However, in the event of illness or other unforeseeable problems that adversely affect resident availability; rotational changes may be made to accommodate patient care responsibilities. In the event of an ongoing manpower shortage, resident workloads will be equitably reassigned. Concerns regarding scheduling should be addressed to the chief resident or the residency program director.

A backup schedule is provided in which all residents are assigned specific backup responsibilities to cover call in the event of unexpected illness or emergency. All residents are responsible for knowing when they are on backup call and being available in case of need. While on backup call, residents need to be available to either hospital (Renown Regional Medical Center or VA Medical Center) within 30 minutes to cover patient care responsibilities. The resident calling in sick or for leave will be expected to pay back the back-up resident for night float, weekends and federal holidays. The resident may also opt to switch a call day on wards for another resident on same rotation. The chief residents must approve repayment of back up.
Scholarly Activity
ACGME places a high priority on all residents be involved in scholarly activity. The program has built in time for residents to work on QI projects, QI training modules, patient safety modules research projects and other scholarly work.

Leave

All residents are permitted up to 15 days of annual leave (vacation), 15 days of sick leave and up to 5 days of CME leave per year at discretion of the Program Directors by the University of Nevada, Reno School of Medicine. If more than a total of one month of time is taken off during the training year for any reason(s), the resident is not eligible for ABIM training credit for that year unless the time is made up by extending training dates. As UNRMed does not charge leave time on weekends, a month as designated by the ABIM is calculated by the program to be 23 working days. Time owed from one training year cannot be made up by forfeiting vacation or other available leave from a subsequent training year. Annual leave must be taken in blocks of 5 days at a time (Monday - Friday)

Annual leave must be planned and scheduled by the start of the academic year. Any changes in the time off requested needs to be approved by the chief resident and the program director. Annual leave must be entered in workday by the resident.

PGY-2 & PGY-3:
Residents at the PGY-2 and PGY-3 level are entitled to 15 vacation days yearly. All vacations must be taken during a subspecialty or elective rotation; however, a resident may not take more than 1 week in any block without specific permission of the program director. Additionally, all vacation must be taken in five-day blocks (Monday – Friday). Changes in leave are only approved by the program director when there are extenuating services. Leave time cannot be carried over to the following year.

It is reasonable to request that if a vacation begins on a Monday, either the weekend before or the weekend after can be requested off (not necessarily both). Generally, the program tries to schedule off both weekends but it is not guaranteed.

If vacation includes a weekday holiday, the holiday counts as a vacation day. If the resident is on an elective, and vacation ends just prior to a holiday, the resident MUST discuss his responsibilities on that holiday with his attending physician before going on vacation. If the attending requests that the resident round on patients that day, the resident must report for duty.

Educational (CME) leave may be provided under certain circumstances for a period not to exceed 5 days per training year. CME leave may only be scheduled during elective months. This leave must be approved by the program director at least 3 months in advance.

Residents interviewing for fellowships may use the 5 days of educational leave for interviews. Once educational leave is exhausted, annual leave must be taken for interviews.
PGY I:
First-year residents are entitled to 15 vacation days yearly. **Vacation must be taken in 5-day blocks (Monday – Friday).** It is reasonable to request that if a vacation begins on a Monday, either the weekend before or the weekend after can be requested off (not necessarily both). Generally, the program tries to schedule off both weekends but it is not guaranteed.

If vacation includes a weekday holiday, the holiday counts as a vacation day. If the resident is on an elective, and vacation ends just prior to a holiday, the resident MUST discuss their responsibilities on that holiday with their attending physician before they go on vacation. If the attending demands that the resident round on patients that day, the resident must report for duty.

Educational (CME) leave for PGY-1 residents is generally only granted in order to take USMLE or COMLEX exams and must be approved in advance by the Program Director.

For PCTT, vacations will be assigned throughout the year and occur at the 5th week of either an elective or inpatient rotation. While the chief residents make every effort to protect residents from call responsibilities for adjacent weekends (before and/or after the five-day vacation time), this is not always possible. Therefore some on-call responsibilities may be assigned before or after the scheduled vacation time.

For PCTT, CME leave may be used to take required USMLE or COMLEX examinations by residents in any year of training with appropriate notice to allow for rescheduling of any conflicting responsibilities.

**Sick Leave Procedure:**
- Inform the attending physicians, chief residents (imchiefs@lists.med.unr.edu) and coordinators (avega@med.unr.edu, moesterling@med.unr.edu, jorgep@med.unr.edu) for any sick calls.
- Call the back-up person (intern-intern) (senior-senior) to cover the assigned duty. Basically the back resident will be responsible for the assigned duty until someone has taken the responsibility.
- Request sick leave in workday

### III CRITERIA FOR SUCCESSFUL COMPLETION OF THE RESIDENCY PROGRAM

A. **CRITERIA FOR SUCCESSFUL COMPLETION OF THE PGY-1 YEAR**

1. Completion with good attendance of 12 months of Graduate Medical Education (GME) training in accordance with a typical Preliminary, PCT or Categorical year as assigned by the program director.
2. Attendance at a minimum of 60% of all required noon conferences, no exceptions.
3. Satisfactory participation and performance on mandatory monthly mini-exams. All PGY-1 residents are required to take and pass all offered exams. (Passing requires at least PGY1 45%) Exams are derived from MKSAP and Med Study predominantly.

*Failure to comply with #2-3 may result in remediation, non-promotion or an unsatisfactory rating in medical knowledge or professionalism on the annual ABIM evaluation.*

4. Satisfactory evaluations throughout the course of the year.
   
a. Milestone Progression Scores over 3 years (see resident evaluations)
   
b. Repeated deficiencies in any core competency will prompt a resident interview with the program director.
   
c. If recommended by the CCC and program director, deficiencies may be addressed a formal remediation program. (See evaluation process)
   
d. Unsatisfactory evaluations in the area of professionalism, or legitimate concerns regarding potential physician impairment are likewise addressed by the CCC, and recommendations for counseling/rehabilitation will be made to the resident.
   
i. Non-compliance with reasonable requests for therapy or continued unprofessional behavior may result in unsuccessful completion of the PGY-1 year and/or non-renewal of the resident contract.
   
ii. In situations where the resident has demonstrated serious breaches in patient confidentiality/safety, the CCC may choose to place a PGY-1 resident on immediate suspension. If the issue is remediable, the resident will be allowed additional time to complete the PGY-1 year.
   
iii. Felony criminal activity or any other activities which may result in loss of the resident's limited state medical license are grounds for immediate termination from the program.

e. PGY-1 resident must demonstrate adequate teaching/mentoring skills before progressing to the PGY-2 level and receive satisfactory evaluations from medical students.
   
i. Remediation programs will be tailored to the resident's needs at the discretion of the CCC and program director.
ii. Significant improvement in teaching skills will result in permission to progress to the PGY-3 year.

f. Due process is available to residents who disagree with unsatisfactory evaluations or a CCC recommendation for remediation, non-promotion or non-reappointment (please see Section III of the “Resident Physician, Resident Dentist and Fellow Handbook of Policies and Procedures”).

5. **Successful completion of all required procedures is expected for promotion to PGY-2 status. (See Invasive Procedures)** Any resident who has not met this requirement may be asked to complete additional remedial time at a PGY-1 level to complete these procedures and may have to extend their overall training dates as a result. Inability to complete all required procedures in a timely fashion during a remediation period may be grounds for non-promotion to PGY-2 status.

B. **CRITERIA FOR SUCCESSFUL COMPLETION OF THE PGY-2 YEAR**

1. Completion with good attendance of 12 months of Graduate Medical Education (GME) training in accordance with a typical second-year schedule as assigned by the program director.

2. Attendance at a minimum 60% of all required noon conferences no exceptions.

3. Satisfactory participation and performance on mandatory monthly mini-exams. All PGY-2 residents are required to take and pass all offered exams (passing requires at least 55% correct score).

   *Failure to comply with #2 or #3 requirement may result in remediation, non-promotion or an unsatisfactory rating in medical knowledge or professionalism on the annual ABIM evaluation. (See evaluation process)*

4. Satisfactory evaluations throughout the course of the year.

   a. Repeated deficiencies in any core competency will prompt a resident interview with the program director.

   b. If recommended by the CCC and program director, deficiencies may be addressed through a formal remediation program. (See evaluation process)

   c. Unsatisfactory evaluations in the area of professionalism, or legitimate concerns regarding potential physician impairment are likewise addressed at the CCC, and recommendations for counseling/rehabilitation will be made to the resident.
Non-compliance with reasonable requests for therapy or continued unprofessional behavior may result in unsuccessful completion of the PGY-2 year and/or nonrenewal of the resident contract.

In situations where the resident has demonstrated serious breaches in patient Confidentiality/safety, the CCC may choose to place a PGY-2 on immediate suspension, or to limit his responsibilities during a probationary period. If the issue is remediable, the resident will be allowed additional time to complete the PGY-2 year.

Felony criminal activity, or any other activities which may result in loss of the resident’s limited state medical license are grounds for immediate termination from the program.

d. A PGY-2 resident must receive satisfactory evaluations from his students and interns demonstrating adequate teaching/mentoring skills before progressing to the PGY-3 level.
   i. Remediation programs will be tailored to the resident's needs at the discretion of the CCC and program director.
   ii. Significant improvement in teaching skills will result in permission to progress to the PGY-3 year.

6. Due process is available to residents who disagree with unsatisfactory evaluations or a CCC recommendation for remediation, non-promotion or non-reappointment (please see Section III of the “Resident Physician, Resident Dentist and Fellow Handbook of Policies and Procedures”.)

C. CRITERIA FOR SUCCESSFUL COMPLETION OF THE PGY-3 YEAR

1. Completion with good attendance of 12 months of graduate medical education (GME) training in accordance with typical third-year schedule as assigned by the program director.

2. Attendance at a minimum of 60% of all required noon conferences, no exceptions.

3. Satisfactory participation and performance on mandatory monthly mini-exams. All PGY-3 residents are required to take and pass all offered exams (passing requires 60% correct score). Failure to meet number 2 or 3 requirement may result in remediation, non-graduation or an unsatisfactory rating in medical knowledge or professionalism on the annual ABIM evaluation.

4. Satisfactory evaluations throughout the course of the year, demonstrating good progression in knowledge base and the appropriate ability to accept clinical and administrative responsibilities.
   a. Repeated deficiencies in core competency will prompt a resident interview with the program director.
b. If recommended by the CCC and program director, deficiencies may be addressed through a formal remediation program. (See evaluation process)

c. Unsatisfactory evaluations in the area of professionalism, or legitimate concerns regarding potential physician impairment are likewise addressed at the CCC, and recommendations for counseling/rehabilitation will be made to the resident.

i. Non-compliance with reasonable requests for therapy or continued unprofessional behavior may result in unsuccessful completion of the PGY-3 year.

ii. In situations where the resident has demonstrated serious breaches in patient confidentiality/safety, the CCC may choose to place the PGY-3 on immediate suspension. If the issue is remediable, the resident will be allowed enough time to complete the PGY-3 year.

iii. Felony criminal activity, or any other activities which may result in loss of the resident's limited state medical license are grounds for immediate termination from the program.

d. A PGY-3 resident must receive satisfactory evaluations from his students and interns, demonstrating adequate teaching/mentoring skills before completing the program.

i. Remediation programs will be tailored to the resident's needs at the discretion of the CCC and the program director.

ii. Significant improvement in teaching skills may allow the resident to successfully complete the residency program.

5. **Due process is available to residents who disagree with unsatisfactory evaluations or a CCC recommendation for remediation, non-promotion or non-reappointment** (please see Section III of the “Resident Physician, Resident Dentist and Fellow Handbook of Policies and Procedures”.)

### IV. Resident Evaluation Process

In accordance with requirements of the ACGME, residents are evaluated using the general clinical competencies in the following measures of professional skills:

**Patient Care (Medical interviewing, examination and procedural skills)**  
Medical Knowledge  
Systems-Based Practice  
Practice-Based Learning  
Professionalism  
Interpersonal and Communications Skills
Core competency Milestones are:

**Patient Care**
1- PC1 Gathers and synthesizes essential and accurate info to define patient's clinical problems
2- PC2 Develops and achieves comprehensive management plan for each patient
3- PC3 Manages patients with progressive responsibility and independence
4- PC4 Skill in performing procedures
5- PC5 Requests and provides consultative care

**Medical Knowledge**
6- MK1 Clinical Knowledge
7- MK2 Knowledge of diagnostic and testing procedures

**Systems-Based Practice**
8- SBP1 Works efficiently within an interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and other support personnel)
9- SBP2 Recognizes system error and advocates from system improvement
10- SBP3 Identifies forces impacting the cost of care, and advocates for, and practices cost-effective care
11- SBP4 Transitions patients effectively within and across health delivery systems

**Practice-Based Learning**
12- PBLI1 Monitors practice with a goal for improvement
13- PBLI2 Learns and improves via performance audit
14- PBLI3 Learns and improves via feedback
15- PBLI4 Learns and improves at the point of care

**Professionalism**
16- PROF1 Has professional/ respectful interactions with patients, caregivers and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and other support personnel).
17- PROF2 Accepts responsibility and follows through on tasks – includes interactions with Coordinators and Admin.
18- PROF3 Responds to each patient’s unique characteristics and needs
19- PROF4 Exhibits integrity and ethical behavior in professional conduct

**Interpersonal communication skills**
20- ICS1 Communicates effectively with patients and caregivers
21- ICS2 Communicates effectively in interprofessional teams (e.g. peers, consultants, nursing, ancillary professionals and other support personnel).
22- ICS3 Appropriate utilization and completion of health records
Milestone Progression Scores over 3 years...

(1) - Exhibits critical deficiencies - Recommend Performance Improvement Plan (PIP) as soon as possible.

(1.5 - 2) Exhibits typical behaviors of a new learner – Typical score for PGY 1

(2.5 - 3) Describes Behaviors of a resident who is advancing and demonstrating improvement in performance related to milestones – Typical score for PGY 2

(3.5 - 4) Ready for unsupervised practice – Typical score for PGY 3

(4.5 – 5) Years of experience, independent, and teaching – Typical score for a preceptor, not a resident

Clinical Competency Committee (CCC)

The Department's Clinical Competency Committee, comprised of faculty members and the Chief Resident(s) meet once per month to discuss individual resident progress using Milestones as the criteria. Each PGY group is discussed 2 times/year. Scores are recorded on the ACGME and AMA web sites and permanent resident records. Residency evaluations are based on Milestones. Competency oriented evaluations are submitted by students, interns, residents, and attending faculty for each rotation. Residents progress through the milestones at different rates. The expectation is that by the end of a resident’s training each of the milestones will be 3.5 or greater with the majority being 4 (ready for independent practice). Its recommendations regarding promotion, remediation, and dismissal are reviewed by the program director for final approval. Such actions are subject to review through the process described under “due process”, including formal review by the department chairman.

The Clinical Competency Committee summary evaluation rests heavily upon the resident’s monthly evaluations from their attending physicians. Residents should be aware that attending evaluations are not averaged by number.

Evaluation Methodology

1) Resident portfolios are kept which reflect educational, research and community activities throughout their academic training.

2) Peer reviews and self-assessment in the ambulatory and inpatient setting in the form of chart audits and morbidity and mortality conferences and presentations.
   - Patient satisfaction surveys
   - Continuity clinic staff evaluations
   - VA nursing evaluations
   - Annual In-Training Examinations
   - Mandatory mini-exams each month

3) Evaluations from nurses, fellow residents, students, as well as the clinical evaluation exercise, the resident's participation in and attendance at morning report, noon conference, journal club,
board review, practice plan seminar, written comments from attendings, and any written letters of praise or complaint are all considered to be integral parts of the evaluation process. Noteworthy performance in the above areas can tip the evaluation process to the resident's advantage in borderline cases. However, any deficiencies brought to light by any of the above mechanisms could be considered sufficient grounds for rendering an unsatisfactory or marginal evaluation, disciplinary action, probation, non-promotion, dismissal from the program, or ineligibility to sit for the ABIM examination.

4) Completion of an academic project during the residency, which may include a CPC conference, poster presentation at a local, regional or national medical conference, original research, submission of a review article to a recognized periodical (categorical residents only), or Goodman competition

5) Medical record completion rate

6) Attendance rates at noon conferences

7) Monitoring of invasive procedures proficiency through didactic testing and supervising physician evaluations

Addressing Deficiencies:

Any resident identified as having a deficiency in any of the above listed proficiencies is brought to the attention of the program director, who will address the issues directly or refer the resident to the next Clinical Competency Committee (CCC) meeting. An ad hoc meeting of the CCC may be called if issues of inappropriate behavior or patient safety are raised. External annual reports on each resident's progress are required by the Nevada State Board of Medical Examiners and the American Board of Internal Medicine.

Process when a deficiency is identified:

The primary goal is to identify a deficiency early so the program can take steps to support the resident in succeeding. An initial step is a performance improvement plan (PIP). The resident will be assigned a faculty member to work with them on the measures laid out in the PIP. This is a non-reportable event to medical boards. Successful completion of the measures will have the resident removed from the PIP. Failure to complete the measures set out in the PIP may result in extension of the PIP if progress has been made or the resident could be put on remediation if progress has not been made. Remediation can be reportable to the ABIM depending on the issue and failure to improve after remediation may result in the training being extended or dismissal from the program. (See Professionalism deficiencies below)

In individual cases, the committee may require a resident to take additional clinical evaluation exercises, oral examinations, or written examinations in order to assess competency.
Any resident deemed unsatisfactory in their annual evaluation for both their PGY-1 and PGY-2 year would not be eligible for advancement to the PGY-3 level and may be required to repeat a year or be dismissed from the program.

Advancement is contingent upon but not automatically granted for a satisfactory overall evaluation.

Disciplinary action for deficiencies will be appropriate for the event(s) and may be carried out and monitored by supervisory residents and/or faculty and, if necessary, by the chief resident(s), program director, and/or chairman of the department. Disciplinary action may consist of reprimand, counseling, probation, non-promotion or demotion, prescriptive assignments, remediation, withholding of privileges or dismissal as outlined above. All disciplinary actions are subject to review through due process.

**Failure to receive a satisfactory evaluation in Medical Knowledge: PGY 1**

i. Improvement in knowledge base may be demonstrated through a series of written or oral examinations by key faculty.

ii. Results from the yearly In-Training examination and monthly mini-exams may be used to tailor a remediation program specific to the resident's needs. However, their scores are not a determinant factor in the evaluation of a resident nor can they result in a prolongation of residency.

iii. Satisfactory progress will result in successful completion of the year.

iv. Inadequate progress may result in the recommendation by the CCC to extend the training at the PGY-1 level beyond the usual 12 months.

v. NON-compliance with a reasonable remediation program will result in an unsuccessful completion of the PGY-1 year which will result in extension of the PGY-1 year or non-renewal of the resident contract

**Failure to receive a satisfactory evaluation in Medical Knowledge: PGY-2**

i. Improvement in knowledge base may be demonstrated through a series of written or oral examinations by key faculty.

ii. Results from the yearly In-Training Examination and monthly mini-exams may be used to tailor a remediation program specific to the resident's needs.

iii. Satisfactory progress will result in successful completion of the year.

iv. Inadequate progress may result in the recommendation by the CCC to extend the training at the PGY-2 level beyond the usual 12 months.

v. Non-compliance with a reasonable remediation program will result in an unsuccessful completion of the PGY-2 year which will result in extension of the PGY-2 year or non-renewal of the resident contract
Failure to receive a satisfactory evaluation in Medical Knowledge: PGY 3

i. Results from the yearly In-Training Examination and monthly mini-exams may be used to tailor a remediation program specific to the resident's needs.

ii. Satisfactory progress may result in successful completion of the program.

iii. Unsatisfactory progress may result in an unsatisfactory rating on the ABIM annual report in individual competencies. In this circumstance, the ABIM will not give training credit for the PGY-3 year, regardless of whether the resident is given training credit by the program. Unsatisfactory progress may also result in an overall unsatisfactory rating to the ABIM; in this circumstance training credit for the year would not be given by the ABIM or the program. In the event of an unsatisfactory rating in the PGY-3 year, additional time may or may not be offered by the program to correct this deficiency.

Due process is available to residents who disagree with unsatisfactory evaluations or CCC recommendation for remediation, non-promotion or non-reappointment (please see Section III of the “Resident Physician, Resident Dentist and Fellow Handbook of Policies and Procedures”.)

Professionalism:

Being professional is critical to long term success in the practice of medicine and it starts in medical school but is strongly scrutinized during your residency.

The residency has some specific expectations that effect your evaluation in professionalism:
- Daily attendance at morning report and ready to start at 8am sharp (Renown), 9:15 (VA)
- Noon conference attendance, in place by 12:10 – 60% required, no exceptions
- Ambulatory clinic in baskets are cleared at least every 24 hours.
- Arrival in clinic by 8 am.
- Ambulatory notes completed by 9 pm the day of clinic
- Hospital notes completed by 9 pm daily
- Grand rounds attendance, very few exceptions allowed

Quarterly completion of all these tasks will be assessed. You will receive a letter of warning with the first episode of noncompliance. You will receive a second warning after the next episode of noncompliance and if this happens a third time a formal letter of remediation will be placed in your file which is reportable to ABIM. Actions will be available on the part of the resident to get this letter removed from the file and will need to be discussed with the program director.

Additional Requirements for Board Eligibility. To be considered eligible for the ABIM Certifying Examination, a resident must:

1. Satisfactorily complete 36 months of training; at least 24 months of which must include meaningful patient responsibility. This will be obtained mainly through required ward, critical care and ambulatory experience.
2. Complete no more than 6 months of non-internal medicine rotations such as Radiology, PM&R, office gynecology, etc.

3. Complete the majority of medicine subspecialty experiences based on educational needs. They must complete at least 4 weeks in the Emergency Department during PGY2 and PGY3, but no more than three (3) months total.

In addition, in the PGY-3 year all residents must be judged satisfactory in each of the six competencies (22 milestones) as well as in overall competence. At the discretion of the Clinical Competency Committee individuals demonstrating deficiencies solely in the areas of professionalism (moral and ethical behavior) may be denied training credit by the ABIM until additional training and/or a specified period of close observation is completed.

V. GENERAL COMPETENCY GOALS AND DEFINITIONS

The goals of the internal medicine program are to:

1. Include the Accreditation Council for Graduate Medical Education (ACGME) general competencies as an integral part of the curriculum.

2. Clearly define characteristics of the competencies and raise awareness of the competencies with residents and faculty.

3. Develop and implement mechanisms to effectively measure competencies.

4. Create milestones for each competency appropriate for each level of training to be used in assessing residents’ progress.

5. Accumulate specific performance outcome information for each core rotation.

6. Evaluate outcome information and dynamically improve the program processes as appropriate.

The learning objectives for internal medicine residents are organized around the core competencies as defined by the ACGME.

Core Competency: Patient Care

Goal: 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.
Progressive Learning Objectives: (Patient Care)

PGY-1 Residents are expected to:

- Demonstrate respect, compassion and empathy for patients and their families.

- Obtain a complete patient history, including relevant information from past medical records, and a comprehensive physical exam for newly encountered patients.

- Obtain a focused, pertinent history and exam for established patients.

- Correctly delineate normal from abnormal physical exam findings, and understand the diagnostic relevance of abnormal findings.

- Integrate information obtained from the history and physical exam to develop a pertinent and prioritized problem list and an initial differential diagnosis.

- Based on the initial differential diagnosis, select initial diagnostic (laboratory, imaging, etc.) studies and therapeutic interventions, with some supervision.

- Integrate the results of diagnostic studies to refine the differential diagnosis. Select additional diagnostic studies and therapeutic interventions based on the refined differential diagnosis, with some supervision.

- Counsel patients/families about their medical conditions and educate them about the diagnostic and treatment plan.

- Routinely address issues of health maintenance and disease prevention with their patients.

- Work toward completing the requirements for technical and cognitive proficiency for invasive procedures, especially those required by the ABIM. Perform invasive procedures under supervision until those requirements are met. The goal being they are all done by the end of PGY 1 unless extenuating circumstances.

- Recognize the role of healthcare providers from other disciplines and services, and work in cooperation with those providers to provide comprehensive, patient-centered care.

PGY-2 Residents are expected to:

- Demonstrate the ability to elicit subtle findings from the history and physical exam, or to augment the physical exam with additional maneuvers as needed to support or refute a diagnostic hypothesis.

- Integrate all information from history, physical exam and diagnostic studies to develop a diagnostic and therapeutic plan with minimal supervision.
Begin to incorporate consideration of risks, benefits, and costs into patient management plans.

Effectively communicate the management plan to patients/families and modify that plan based on their values and preferences.

Begin to utilize information technology to retrieve and apply current medical evidence (e.g. guidelines, original literature) to refine the patient management plan.

Initiate and coordinate the involvement of healthcare providers from other disciplines and services to provide comprehensive, patient-centered care.

Complete the requirements for technical and cognitive proficiency for invasive procedures, especially those required by the ABIM. Perform invasive procedures under supervision until those requirements are met.

PGY-3 Residents are expected to:

Integrate all information from history, physical exam and diagnostic studies to develop a diagnostic and therapeutic plan at the level of a general internist without need for supervision.

Consistently incorporate consideration of risks, benefits, and costs into patient management plans.

Consistently utilize information technology to retrieve and apply current medical evidence (e.g. guidelines, original literature) to patient management.

Function competently as an internal medicine consultant to other services.

Core Competency: Medical Knowledge

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

Progressive Learning Objectives:

PGY-1 Residents are expected to:

Have a basic understanding of the mechanism of diseases commonly encountered in an internal medicine ambulatory clinic and on internal medicine inpatient services, as demonstrated by:

The ability to define an “illness script” for these conditions that includes the risk factors for the condition, the pathophysiologic insult, and the presenting signs and symptoms.
The ability to develop an appropriate initial diagnostic and treatment approach to these conditions, with some supervision.

Learning the risks and benefits of commonly performed procedures

Display an attitude of inquisitiveness and a desire to continuously expand their knowledge base.

Utilize reference materials (e.g. textbooks, Up-To-Date®, pocket references) to correct deficits in knowledge related to the diagnosis and treatment of the patients for which they providing care.

Attend at least 60 % of teaching conferences.

Achieve a 45% correct score on the monthly mini exams.

Take and pass the USMLE Step 3 examination by June 30th or completion of their intern year.

PGY-2 Residents are expected to:

Have more in-depth understanding of diseases commonly encountered in an internal medicine ambulatory clinic and on internal medicine inpatient services, as demonstrated by the ability to develop an appropriate initial diagnostic and treatment approach to these conditions, with minimal supervision.

Utilize current medical evidence (e.g. guidelines, original literature) to correct deficits in knowledge related to the diagnosis and treatment of the patients for which they providing care.

Develop a plan of systematic, independent study to expand their knowledge of internal medicine and its subspecialties.

Attend at least 60% of teaching conferences

Achieve 55% score on all monthly mini exams

PGY-3 Residents are expected to:

Have an understanding of diseases encountered in an internal medicine practice that is appropriate for a general internist, as demonstrated by the ability to develop a comprehensive diagnostic and treatment approach to these conditions without supervision.
Have a basic understanding of unusual or complex diseases commonly encountered in the subspecialties of internal medicine, as demonstrated by the ability to:

- Develop an appropriate initial diagnostic and treatment approach to these conditions.
- Refer to a consultant, when appropriate

- Score 60% on all monthly mini exams

- Utilize the medical literature to address queries for areas of controversy and to also inform PGY1 and 2’s under their supervision regarding standards of care.

- Attend at least 60% of teaching conferences

Core Competency: Practice-Based Learning and Improvement

Goals: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Progressive Learning Objectives:

PGY-1 Residents are expected to:

- Be able to supervise and teach 3rd year medical students. Seek and accept feedback from students and use that feedback to improve their teaching and supervisory skills.

- Seek and accept feedback from attendings and supervising residents, and utilize that feedback to improve their clinical performance.

- Set short-term learning goals for each rotation they perform. Evaluate their own performance relative to those goals at the beginning and end of each rotation.

- Perform competency-based, semi-annual self-assessments.

- Be able to formulate clinically relevant, questions related to the diagnosis and treatment of their patients’ medical conditions.

- Be familiar with common databases of medical literature (e.g. Medline) and common search engines (e.g. PubMed, etc.).

- Participate in quality improvement projects in the ambulatory clinic, including the collection of data by chart review, discussion of the data to identify opportunities for improvement, and development of interventions to improve the systems of care and overall quality of care delivered in the clinic.

- Learn basic principles and methodology of Clinical Quality Improvement (CQI) and construct and present an idea for a CQI project.
PGY-2 Residents are expected to:

- Be able to supervise and teach 4th year medical students and interns. Seek and accept feedback from students and interns, and use that feedback to improve their teaching and supervisory skills.
- Seek and accept feedback from attendings, and utilize that feedback to improve their clinical performance.
- Set longer-range learning goals for their residency training. Develop learning plans to help achieve those goals and a method of evaluation to determine their success in meeting them.
- Know basic methods for searching the medical literature, and be able to find original medical literature related to the diagnosis and treatment of their patients’ conditions.
- Be able to critically appraise literature related to diagnosis and treatment, and appropriately apply the results of that literature to their clinical practice.
- Learn basic principles and methodology of Clinical Quality Improvement (CQI) and construct and present an idea for a CQI project.

PGY-3 Residents are expected to:

- Be able to present effective teaching conferences, including Morning Report and a Clinical Pathological Conference.
- Learn basic principles and methodology of Clinical Quality Improvement (CQI) and construct and present an idea for a CQI project.
- Be able to discuss the principles of executive management skills and develop a personal improvement plan.

Core Competency: Interpersonal and Communication Skills

Goals: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families, and professional associates.

Progressive Learning Objectives:

PGY-1 Residents are expected to:

- Provide verbal presentations that are thorough, yet succinct and pertinent, and that reflect understanding of the patients’ condition and/or support a differential diagnosis.
- Provide notes that meet the same criteria.
o Provide written/electronic and verbal sign-out of patients that is efficient, pertinent, and explicit.

o Be open and receptive to questions and recommendations from members of the nursing staff and ancillary healthcare services.

o Develop a therapeutic relationship with patients and their families, regardless of their background.

o Be able to explain a patient’s condition and plan of care to the patient and family in terms that are understandable and appropriate.

o Be able to discuss the risks and benefits of procedures or interventions with patients and families, and obtain informed consent.

o Be able to discuss resuscitation status with patients and families, answer their questions regarding this issue, and elicit the patient’s wishes in regard to cardiopulmonary resuscitation.

o Communicate expectations to 3rd year students and provide them with feedback.

PGY-2 Residents are expected to:

o Provide senior admission notes that succinctly summarize the patient’s condition, reason for admission and management plan.

o Dictate/type discharge summaries that succinctly summarize and convey the pertinent details of the patient’s hospitalization and post-hospitalization follow-up needs.

o Effectively communicate verbally with consulting physicians. Be able to succinctly summarize the patient’s condition and the explicit reason(s) why consultation is being requested.

o Effectively communicate and coordinate the plan of care with nursing staff and members of ancillary healthcare services.

o Engage patients and their families in shared decision-making, especially in situations whether there is clinical uncertainty and/or ambiguity.

o Lead family/team meetings, with some support from the attending physician, including discussions of end-of-life care.

o Be able to resolve conflicts with patients/families, staff, or within the team, with some involvement of the attending physician.
Communicate expectations to 4th year students and interns and provide them with feedback.

PGY-3 Residents are expected to:

- Effectively communicate with physicians as a consultant, and be able to provide succinct, explicit recommendations both verbally and in writing.
- Lead family/team meetings, with minimal or no support from the attending physician, including discussions of end-of-life care.
- Be able to resolve conflicts with patients/families, staff, or within the team, with minimal or no involvement of the attending physician.

Core Competency: Systems Based Practice

Goal: 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.

Progressive Learning Objectives:

PGY-1 Residents are expected to:

- Complete all charting/documentation/dictations in a timely manner.
- Learn the role of other members of the healthcare team, including case managers, social workers, physical/occupational/speech/respiratory therapists, nutritionists, clinical pharmacists, and others.
- Recognize when their patients may benefit from the involvement of other healthcare providers, and invoke their assistance when appropriate.
- Learn what evidence-based guidelines and standardized order sets are available in our institution. Know how to find these resources, and utilize them when appropriate for patient care.
- Learn to proactively identify threats to patient safety and to address system errors.
- Learn the importance of effective patient hand offs.

PGY-2 Residents are expected to:

- Effectively coordinate the involvement of healthcare providers from other disciplines and physicians from other specialties to provide comprehensive, patient-centered care.
o Learn to anticipate patients’ discharge needs (e.g. transportation and medication assistance; need for placement, home health care, and durable medical equipment; etc.), and begin discharge planning early in their hospitalization, with some prompting by the attending physician

o Demonstrate skill in effective and safe patient sign outs when transferring care.

**PGY-3 Residents are expected to:**

o Consistently anticipate patients’ discharge needs and begin discharge planning early in the hospitalization, with minimal or no prompting by the attending physician.

o Describe the basic systems of payment for health care, and the principal types of payers for health care.

o Demonstrate understanding of commonly used coding systems and describe the relationship between supporting documentation, accurate coding and reimbursement.

o Demonstrate understanding of basic principles of healthcare management systems.

**Core Competency: Professionalism**

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

**Progressive Learning Objectives:**

PGY-1, PGY-2, and PGY-3 Residents are expected to:

o Develop a true sense of responsibility towards the care of one’s patients

o Treat all patients, regardless of background, with respect, compassion and empathy.

o Treat everyone else – nursing staff, ancillary healthcare providers, program personnel, students, residents from our own and other programs, attending physicians in all specialties, others – with respect and courtesy, and in a way that reflects positively on them as individuals and the medical profession as a whole.

o Respect patients’ autonomy and their right to make informed decisions about their own health care.

o Commit to advocating for their patients’ needs in the healthcare system, and be willing to place the patients’ needs above their own.

o Commit to provide the highest quality, most effective and most efficient care that their experience and level of training permit.
o Understand and safeguard patient confidentiality and protected health information.

o Be honest in all aspects of their professional life, including documentation of patient information, disclosure of medical errors, and acknowledgement of deficiencies in medical knowledge and clinical skills.

o Be committed to self-directed learning, self-evaluation, and self-improvement.

o Comply with the policies and expectations of the residency program, and complete administrative tasks (e.g. evaluation forms) on time.

o Be willing to assist their colleagues and the program with patient care and service coverage when needed.

VI. GENERAL EXPECTATIONS OF RESIDENTS

In general, all residents are expected to:

1. Utilize the curriculum information for their specific rotations to develop a program of study with the appropriate guidance of their faculty mentor.

2. Fully participate in the educational activities of their program and assume responsibility for supervising and teaching other residents and medical students.

3. Attend and participate in scheduled conferences (i.e., morning report, morbidity and mortality conferences, noon lectures, journal club and board review). It is understood that not all conferences can be attended; however, these are an important part of a resident's education. Attendance is expected unless patient care would otherwise be jeopardized. Residents are excused from noon conference attendance when they are rotating on night float, if they are the post-call, Elko rotation, on vacation or other approved leave. As well, senior residents who may not leave the hospital due to code team responsibilities will be excused if when noon conference is being held at a different site. Residents are required to otherwise attend a minimum of 60% of noon conferences. Inadequate attendance may result in academic probation, an unsatisfactory overall annual evaluation, and may be used as grounds for non-promotion or dismissal from the program.

4. In general, the department tries to provide a meal to accompany the noon conference. There is no requirement for the department to provide food at every noon conference, and attendance is mandated whether or not food is available. It is expected that residents receiving meals respond in a gracious and professional manner. Abuse of this privilege will result in suspension of lunches for a specific period of time.

5. Provide appropriate, timely, safe, cost effective, high quality and compassionate care to all patients, commensurate with their level of training.
6. Respect and strictly adhere to the policies of the medical practice at each participating hospital including the timely completion of medical records.

7. Provide thorough, complete and prompt documentation of all aspects of patient care.

8. Be available by cell phone with a valid number Monday - Friday, 6:00 a.m. – 4:30 p.m. (at which time you must sign out to the answering service), and whenever on call or rounding on weekends. Exceptions to the above include approved leave and days off.

9. Notify the program coordinator (Monica Oesterling /Ana Vega), your attending physician, residents who are covering your duties, your clinic attending, the answering service (352-5100) and the program director of any illness or unscheduled leave. If you need backup coverage of call responsibilities, you also need to call the chief resident on call. It is the resident's responsibility to notify the continuity clinics at UNR-MED if they are unable to attend clinic that day due to an EMERGENCY. Your scheduled patients will be reviewed and, if possible, rescheduled to your clinic at a later date.

10. Fulfill all clinic and call obligations. All changes to these schedules must be submitted to the chief residents and are subject to final approval by the Program Director. A pattern of unreliable attendance reflects a lack of professionalism and may result in a hearing before the Clinical Competency Committee or other adverse action. All clinic and call schedules are available online at www.amion.com; the program password is unsomim. These schedules are updated in real time with any approved changes. It is the responsibility of all residents to monitor these schedules regularly to make sure they are aware of all scheduled duties as well as to monitor for possible scheduling errors or conflicts. Any discrepancies found in these schedules need to be reported to the program director and/or chief resident promptly.

11. Complete all evaluations of students, residents, and faculty and rotation experiences in a timely manner (within 1 month of completion of the rotation).

12. Keep consultants, ward attendings, and on-call attendings informed of any major change in patient status as well as any moral, legal or ethical problems.

13. Perform any additional duties as assigned by the Chief Resident or Program Director.

14. Evaluate at the bedside (not over the phone) any patient concern voiced by a staff nurse.

15. Call or write orders for non-resident patients only under emergency or potentially life threatening situations. (See policy regarding non-teaching patients.)

16. Residents are expected to check their UNRMed e-mail daily and use only this e-mail for all residency related matters. The med.unr.edu server is HIPAA compliant and thus is acceptable for transfer of patient information. Additionally, the program and the department
will use this address only to inform you of residency related information. Failure to monitor this e-mail will be considered a breach of program requirements and professionalism standards.

17. **PC Track trainees** will be assigned to “buddy” groups of two for which one will be assigned to HOME BASE while the other is on an inpatient rotation or outside elective. The buddy at HOMEBASE bears responsibility for checking the in basket on EPIC for his partner **when that partner is on vacation** to make certain that all labs are reviewed, prescriptions filled and any patient advice queries and answered in a timely fashion. As long as the resident is in town they are responsible for clearing their in basket. After 5 pm, holidays and on weekends the resident on home call is required to check and clear the in basket of all other PCT residents; duties including refilling chronic disease management med (no narcotics), checking lab results and answering any patient queries.

18. Dress and act in a professional manner at all times.

a) No jeans are permitted during any rotations, at any time.

b) Scrubs are permitted but not required when on call on wards. They are permitted during a. ICU rotations at both the VA and Renown or when on a rotation in which they are required for certain procedures. Examples include cardiac cath, bronchoscopy, colonoscopy, etc. Scrubs are never permitted while in outpatient clinics.

c) T-shirts are permitted to be worn anytime scrubs are permitted, but at no other times.

d) No open-toe shoes are allowed while on rotations in which patient care is occurring.

e) **No gum chewing is allowed when performing duties directly with patients**

VII. WARD MEDICINE AND CRITICAL CARE ROTATIONS

GENERAL RESIDENT RESPONSIBILITIES

**PGY-1 Residents**

1. Primary responsibility for moment-to-moment, daily and overall patient care on inpatient rotations.

2. Perform daily work rounds, examine patients and gather information for discussion purposes on each patient prior to attending rounds.
3. The PGY-1 is required to remain in-house until his patient care duties have been completed or arranged to be completed by another resident. It is expected that the PGY-1 will examine every patient admitted to their service and will:

   a. Perform and document comprehensive H&Ps on all patients admitted or transferred to their service. **Co-signature of an MS-III H&P is not sufficient; all patients require a resident H&P.**

   b. Enter daily progress notes on all patients admitted to their service or for whom they have assumed responsibility for that day with the following exceptions:

      i. When the supervising resident or cross-coverage team of physicians accepts the responsibility for note writing.

      ii. ICU patients that transfer out after noon should have a brief acceptance note.

   c. Enter a discharge note, arrange medications and follow-up and educate patients on discharge instructions on the day of discharge for all patients. First 6 months of training, seniors will do discharge summaries.

   d. Enter and/or dictate procedure notes for each procedure they perform (not merely assist at). Remember to have a copy sent to the program office to be placed in your training file. Be sure to include the names of the residents and attending physician who were also in attendance in the note.

   e. As the primary caregiver, take initial calls and address any concerns of the patient, the patient's family, nurses or other health professionals. When on call, provide similar care for any patient on a teaching service.

   f. When on call, address any patient concern in person at the bedside and not over the telephone. Cross-cover documentation in a progress note, including the presenting problem, pertinent physical findings, laboratory examinations, X-ray findings, an assessment and a therapeutic and diagnostic plan is required in all cases. Exceptions are conditions that are clearly minor, such as mild constipation.

   g. Enter admitting and daily orders, follow up on all laboratory and X-ray data, contact consultants, and coordinate care from the interdisciplinary treatment team.

   h. Enter concise but accurate off-service notes on the day prior to switch for the patients that have been on the service greater than 5 days.
i. Participate in a responsible checkout process. Provide the on call team with a written AND verbal face-to-face sign out of all patients prior to leaving at the end of the day. Checkouts may be done no earlier than 4:30 pm Monday through Friday (excluding holidays); PGY-1 residents are to be available to meet all patient care needs until at least that time. Under no circumstances will an unstable patient be checked out. It is the responsibility of the team to stabilize the patient prior to leaving the hospital premises. Repeated failure to provide an appropriate checkout to the on call team may result in disciplinary action.

4. PGY-1’s are expected to call their senior resident:
   - When faced with a patient care or administrative problem that they are unfamiliar with.
   - For direct supervision of all invasive procedures (with faculty approval and supervision).
   - To change the code status of a patient.
   - To assist in settling disagreements with nurses, consultants, other health professionals, or patients.
   - When dealing with patients on non-teaching services.
   - Regarding cross coverage calls on patients at RRMC in the ICU or CCU.

5. PGY-1’s are not responsible for:
   - Disputing the appropriateness of admissions.
   - Determining discharge timing.
   - Independently determining or writing code status orders.
   - Rendering internal medicine consultations.
   - Accepting transfers.
   - Handling calls regarding outpatients, unless it is regarding one of their own continuity clinic patients.

If a PGY-1 is uncomfortable or dissatisfied with the advice, teaching or supervision provided by his supervising resident, he should call his attending physician immediately. If problems still persist, please contact the Chief Resident, the Program Director in that order. After hours or on weekends contact those people through the answering service (775-352-5100) or by cell phone.

**PGY-2 and PGY-3 Residents**  [Also see specific rotation curriculum for further details.]

1. Assume responsibility for organizing their team’s schedule to ensure that all team members have one day out of seven free of hospital duties when averaged over four weeks. The senior resident is also responsible for ensuring the compliance of all team members with the ACGME mandated work hours restrictions. This may include reassigning patients or individual patient care activities to balance intern workloads and ensure compliance with work hour restrictions.
2. Enter/dictate all discharge summaries for patients assigned to their team for the entire academic year. Exceptions are made for when the senior is off that day and a timely discharge summary needs to be done. In that instance, then the PGY-1 on the team would assume responsibility.

3. Help assure that teaching and work rounds are conducted and completed in a timely fashion.

4. See and examine all new patients, write a concise but thorough senior admission note on all patients they admit, accepted in transfers, or for whom they assume care. Senior residents are also required to write H&Ps on patients without the PGY-1 when the on call PGY-1 has already admitted 5 new patients within a 24-hour period. The senior resident is responsible for ensuring that there is documentation immediately available on each patient chart sufficient for good patient care until any dictated notes become available.

5. Perform and document internal medicine consultations, including dictating notes and performing procedures under the direct supervision of the subspecialist or attending physician.

6. Round and physically see every patient on your service outside of attending rounds and write appropriate notes.

7. Senior residents must work with their interns to formulate plans for every patient every day prior to daily attending rounds. Senior residents will also place all calls to consultants after the attending has approved the consult.

8. Supervise and be responsible for the work of the PGY-1(s) and medical students assigned to their team.

9. Supervise at the bedside, all invasive procedures performed by any PGY-1 for whom they are responsible (not necessary when an attending physician is at the bedside).

10. Dictate or write and log procedure notes on all procedures they personally perform (not supervise).

11. Address any calls or concerns brought to them by any students, PGY-1 residents, patients, nurses or other health professionals, consulting staff or attending physician, or patient's family, and document all pertinent discussions, decisions, etc. in a progress note.

12. Address code status of patients for whom they are responsible and discuss the matter with their attending physician within 24 hours of writing any orders or notes regarding code status.

13. Assume all responsibilities of their PGY-1’s when that PGY-1 is unavailable.

14. Always be available to support the interns on the team and also be available to cross cover interns of other teams in wards when the senior is on call and other team’s interns are without a senior (e.g. senior day off)
15. Document any involvement in the care of cross coverage patients when on call.
16. Discuss with supervising or attending physician any invasive procedure prior to its execution. Discuss in depth the indications, risk/benefits, actual performance of the procedure, follow up management and level of supervision.

17. Review their medical students' H&P examinations and review specific topics of interest daily.

18. Serve as a teaching resource by reviewing specific topics requested by attendings, interns or students. Provide students with reading directed towards their patients' problem.

19. Take responsibility for assuring that their team is available for morning report on time.

20. Participate in complete and organized sign out when acting as a supervising or cross covering resident. **Check out any potentially unstable or Critical Care, Cardiac Care or ICU patients to the senior resident on call face-to-face.**

21. Participate in check out rounds in the ICU when on call at the VAMC.

22. VA Standard Work flow for Wards/ICU - see appendix B

23. RRMC Standard Work flow for Wards/ICU - see Appendix C

24. Contact the appropriate senior resident regarding any transfer in or out of the CCU, ICU or Cardiac Care Unit. ICU distribution of patients to the medical floor is the senior’s responsibility.

25. Ensure compliance of their team with all applicable residency program, hospital, UNRMed and ACGME requirements including but not limited to:
   a. Intern and senior admission and census caps
   b. Closures
   c. Work hours
   d. Days off
   e. Assess for conflicts in schedule.

26. Senior residents are expected to call their attending physician:
   a. For issues regarding code status (see above).
   b. When faced with a patient or administrative problem with which they are unfamiliar or have questions about.
   c. To help settle any disagreements with nurses, consultants, patients, other health professionals or patients' families.
   d. When, after directly triaging a patient, they question the appropriateness of an admission or transfer. **AN ATTENDING PHYSICIAN MUST PERSONALLY EXAMINE AND DISCHARGE A PATIENT IF THEY DISAGREE WITH AN ER PHYSICIAN ABOUT ADMITTING THAT PATIENT.**
e. To determine discharge timing.

f. **Prior to any consult being requested and call the consultant themselves.**

g. Prior to accepting transfers from other hospitals.

h. Prior to performing any invasive procedures.

i. To discuss any consults rendered

27. Senior residents are not responsible for:

a. Determining whether or not to accept transfers from other hospitals.

b. Performing procedures without appropriate supervision by an attending physician or other qualified medical staff member or resident who is credentialed to perform that procedure. Policies regarding qualifications to perform procedures must be adhered to at each of the teaching hospitals.

28. If a senior resident is not satisfied with their attending physician’s advice or supervision, they should attempt to resolve the issue with their teaching attending in an amicable fashion. If they cannot, they should contact the Chief Resident, then the Program Director and in that order. After hours or on weekends either the Chief Resident(s), Program Director via the answering service (775-352-5100) or cell phone.

29. RRMC ER/VA Emergency Department Admissions

   a. On occasion, differences of opinion have arisen between emergency room physicians and senior resident physicians on call regarding the necessity of hospitalization of a patient. If there is a difference of opinion, the resident is expected to behave in a courteous and professional manner. Options include:

   i. Admitting the patient overnight, and discuss discharge after short-stay with the attending physician during rounds the next morning

   ii. Asking the emergency physician to reassess the patient with you to see if they feel the patient has stabilized sufficiently to be safely discharged

   iii. Call your attending physician, requesting that they come in to evaluate the patient with you, and determine if the patient is to be accepted to the service.

**VETERANS AFFAIRS MEDICAL CENTER (VAMC):** (detailed work flow see appendix B)

**VAMC Ward Medicine:**

There are three ward teams, two of which consist of one attending physician, one senior resident, and two interns. One team consists of one attending, and two senior residents. The ward teams round daily with their attending physician. The senior residents are responsible for arranging scheduling for all team members to have 1 day off in 7 when averaged over the 4 week period, to be based on the admitting responsibilities of the interns and personal preferences. Days off should be scheduled on weekends/FEDERAL holidays as much as possible to minimize absence at teaching conferences. Please note that “State” holidays are not recognized at the VA, and only “Federal” holidays are observed. The senior residents will be responsible for assuming or reassigning care of ward patients when the primary intern is not available. Ward team members are required to sign out all patients to the physicians on call before leaving the hospital.
The Long Call senior resident team will admit patients from 6am to 11am, as well as cover consults during that time. The Short Call senior resident team will admit and cover consults from 11am to 3pm. The Long Call senior team will resume these responsibilities again from 3pm to 6pm. The Night Float senior team will resume those responsibilities, as well as cross-coverage issues throughout the whole hospital, from 6pm to 6am.

On weekends and federal holidays, the Long Call Senior team will admit from 6am to 6pm, including ICU admissions that day. The Night Float senior team will resume these responsibilities from 6pm to 6am every day.

The ward senior resident on call is responsible for providing any requested internal medicine inpatient consultations under the supervision of the ward attending. When ICU residents are on service then they are responsible for ICU consults to medicine. All other hours the on call senior resident will cover and discuss with ICU attending. Patients will be followed by the consulting resident and attending until no longer warranted by the patient's condition. Interns are expected to assist in all procedures performed on their patients. Progress notes are expected on all patients daily, with additional documentation for unexpected interim events.

**VAMC ICU Medicine:** There will be one ICU team consisting of one senior resident and one to two interns. The senior resident is responsible for equitably distributing ICU admissions to ICU interns from 6am until 4:30 pm weekdays. At 4:30 pm-6:00 pm on weekdays, as well as 6am-6pm during weekends and Federal Holidays, all ICU admissions/transfers are done by Long Call Ward Senior. The Night Float senior will do this from 6pm-6am. On weekends and holidays, all daytime admissions to the ICU will be done by the Long Call Senior team, but responsibility for patients will be assigned the following day by the senior resident with the goal that intern workloads will be distributed as equitably as possible. ICU senior residents expected to remain in hospital until 6:00 pm with on call intern. Non call intern may leave at 4:30 pm if work is done.

ICU residents are expected to round several times daily on their patients, and to be available to participate in all procedures performed on their patients. They will work under the close supervision of the ICU attending physician. Family Medicine interns will have commitments outside of the ICU, and will be allowed to carry out those commitments with appropriate coverage of their patients by the remainder of the ICU team.

The ICU senior must be available at all times to supervise the activities of their interns. This senior is also responsible for carrying the VAMC code pager, and for delegating responsibility for the code pager to another senior resident when they will not be available to respond to code situations. The ICU senior or on call senior will also be a member of the Rapid Response Team (RRT); and are responsible for being an active member of the Code Blue/Rapid Response Team throughout the hospital, including primary care, ED, wards, specialty clinic, ICU, CLC, and anywhere that an overhead page/code page requires the attention of the rapid response/code blue team.
The ICU senior resident is responsible for providing any requested internal medicine inpatient consultations in the ICU under the supervision of the ICU attending. The senior resident is required to completely assess any consult patients before contacting the attending to discuss the patient; then to write a consult note as well as communicating any urgent suggestions to the managing team directly. Patients will be followed by the consulting resident and attending until no longer warranted by the patient's condition.

Proceedures on ICU patients are expected daily, with additional documentation for any unexpected interim events.

**Accepting Admissions:** Although most patient admissions are from the Emergency Department, on occasion, residents may be contacted by a clinic health care provider requesting direct admission of a patient. In that situation, the admitting resident is expected to report to the clinic in a timely fashion, evaluate the patient face-to-face, and either admit the patient to the appropriate service, or contact his attending physician to discuss the patient if they believe that admission is not warranted or the patient’s medical issues can be best handled through an alternate disposition. It is expected of the admitting resident that they contact Utilization Management and Bed Control (nursing supervisor) prior to writing orders, to ensure appropriate disposition and utilization.

**Morning Report:** All VA ward teams as well as the ICU team are required to attend Morning Report at 9:15am-10:00am, with the exclusion of attending permission and patient care emergencies. Those rotating on VA geriatrics, pulmonary, cardiology, neurology, nephrology, and ID are exempted, but are encouraged to come if permitted by their attending and clinical duties. Morning Report typically is held in room C2353, Monday through Thursday. Monday morning reports are usually administrative or a didactic lecture from a subspecialist or a pharmacist. On Friday, Morning Report mandates the Night Float team’s presence as well, and will occur from 7:30am to 8:00am, and the focus of Friday’s morning report is that of the night float team’s management plans. The content in morning report Tuesday through Thursday can vary, with the discretion of the presenting team. Morning report does not exist on Federal Holidays or weekends.

**RENOWN REGIONAL MEDICAL CENTER (RRMC):** There are four general medicine services and one critical care service. (Detailed work flow Appendix C)

**General Medical Service (GMS):** There are 4 GMS services at RRMC A (Blue/Gray), B (White/Orange), C (Green/Purple) and D (Red/Yellow). All teams are comprised of a faculty attending, one senior resident and two interns. Senior residents may admit up to 10 patients during each call assignment (day or NF) and may accept an additional 4 patients in transfer. From 6pm to 6am, all admissions will be taken by the night float team and these patients will be equitably distributed to any available team during morning sign out the following day. See above for senior responsibilities for distribution pattern. Admissions from University Health Systems (UHS), 24 hours daily despite patient census or number of admissions during the day.
The on call senior resident is responsible for doing all medicine consultations requested of the University teaching services M-F 6am to 6pm under the supervision of their faculty attending. Consultations requested from 6pm to 6am daily will be the responsibility of the senior resident on call under the supervision of the on-call attending physician; any follow-up required for that consultation will be provided by the consulting team intern with supervision and assistance from the supervising attending and senior resident.

GMS residents are expected to round daily on all patients on their service, provide all care needed as in the general responsibilities outlined in section VI and to directly sign out all patients to the on call team prior to leaving for the day. The senior resident/intern on call for the day and the night float senior resident/intern are members of the RRMC code team and as such, must respond to all Code Blue situations involving UNR patients and work there under the supervision of the code leader (generally the ER physician).

**Critical Care (CC):** The critical care (Gold) team is the admitting team of record for all university patients (as defined above) admitted to any of the RRMC critical care units. That team will consist of the critical care attending on call, three senior residents and is expected to provide care to patients 7 days a week under the supervision of the critical care attending. The senior residents is responsible for making a schedule to cover patient care responsibilities on weekends to allow for required days off for all team members over the 4 week block. The CC (Gold) team will provide care to all assigned patients for as long as the patient remains in a CC bed, even if the patient no longer needed critical care services but remains due to logistical issues. Pulmonary Medicine Division of Renown Medical Group (PRMG) has agreed to provide care for these patients as well as supervision and teaching for the CC residents. When a patient is appropriate for a lower level of acuity, that patient will be transferred to the general medicine teams as noted above in senior responsibilities for distribution. The CC senior resident must give a verbal report of care to the accepting senior resident (accepting senior during regular hours or the on call senior if after regular hours) as well as dictating or writing a transfer summary. The CC team may directly accept any admissions to critical care units from 7am to 430pm M-F as well as accepting patients in transfer from the on-call or night float teams every day. The critical care team is responsible for rounding on their patients daily, and writing progress notes; the team is also expected to participate in all procedures and ventilator management for patients under their care. The senior resident is responsible for knowing all patients on the service and is required to complete all transfer/discharge/death summaries for all CC patients. Senior residents will not be scheduled for any continuity clinics while on the CC rotation. Each senior resident may take care of up to 14 patients. In the event of there being more than 14 patients per resident (such as when a resident has a day off), the senior resident is responsible for deciding with the supervising critical care attending which patients will be changed to non-teaching service.

**VIII. SUBSPECIALTY, ELECTIVE AND OTHER ROTATIONS**

(For detailed goals and objectives on subspecialty rotations, please review the online curriculum)

**All residents must:**
1) Contact their preceptor one week prior to starting the rotation
2) Fulfill patient/didactic responsibilities as dictated by their preceptor and as outlined in the curriculum for that rotation.
3) Attend all scheduled continuity clinics.
4) Fulfill call responsibilities as dictated by the program.
5) Fulfill all responsibilities outlined previously.
6) Write a subspecialty progress notes on all patients seen and have it countersigned by their preceptor after discussing the case with them.
7) Check out any potentially unstable patient to their immediate supervisor.

PC Track Trainees: all of the above apply with the following exceptions:

1. All PCT trainees will do a five week block of subspecialty rotation but the 5th week at discretion of the Program Director may be reserved for the following:
   a. Vacation time
   b. Emergency room rotations
   c. Completion of research or QI projects
   d. Remediation assignments and evaluation with PD

Note: all PC Trainees during subspecialty rotation need to inform their supervising faculty that they are obligated to attend Team Based Learning on Tuesday afternoons.

IX. INVASIVE PROCEDURES

A. SUPERVISION regarding all invasive procedures:

1. An appropriately credentialed attending physician must:

   a. be responsible for supervising the procedure.
   b. be notified prior to performance of the procedure or obtaining consent from the patient or surrogate.
   c. discuss the indications, risks, benefits, technique, possible complications, and follow-up care with the resident.
   d. be present at the bedside at VAMC and RRMC unless in the attending's judgment an individual senior resident is capable of performing or supervising the procedure with supervision from the attending via telephone contact within or outside the hospital. This will generally be granted to a resident after performing the minimum required numbers of that procedure, as documented in the resident's procedure log. A list of “signed-off” procedures which the resident may perform independently with consent from the supervising attending physician will be maintained by the program office and updated monthly with the results available online to all staff for reference. The requirements for being signed off and the procedures that may be performed independently is different at the two hospitals and it is the responsibility of all residents and supervising faculty to check
whether the resident is approved for independent performance of procedures. Regardless of perceived or documented skill or experience, PGY-1 residents may not perform any invasive procedures without bedside supervision from an attending or appropriately credentialed senior resident. See C below (Privileges to perform procedures independently).

e. complete a PROCEDURAL SKILLS ASSESSMENT FORM documenting the resident’s proficiency and professionalism in performing all directly supervised procedures.

2. Informed consent must be appropriately obtained and documented prior to initiation of the procedure.

3. A written or dictated procedure note must be completed. A copy of the dictated procedure note must be sent to the program office along with the Procedural Skills Assessment Form completed and signed by the supervising physician.

4. The person performing (not assisting or supervising) the procedure should dictate or write the procedure note, noting which residents/attending were also in attendance.

It is recommended that prior to performing a procedure the resident make use of the online resource Procedures Consult under Clinical Key at http://guides.library.unr.edu/c.php?g=178324 OR go to the library home page (http://campusguides.unr.edu/savitt) and click the ‘clinical tools’ tab.

B. PROCEDURES REQUIRED/RECOMMENDED BY THE AMERICAN BOARD OF INTERNAL MEDICINE (ABIM)

Although the ABIM no longer requires documentation of proficiency for many invasive procedures, numerous procedures are still required by the residency program. At the conclusion of training, each resident must be judged by the program director to be proficient in the procedures listed below. The minimum number of directly supervised, successfully performed procedures for each required procedure is indicated in parentheses below:

abdominal paracentesis (5)
arterial puncture (5)-ABGs do not require patient note
arthrocentesis (5)
central venous catheter placement (5)
lumbar puncture (5)
thoracentesis (5)
pelvic examinations and pap smear (5)-do not require patient note
critical life-saving procedures (this requirement can be met by documentation of successful training in advanced cardiac life support)
EKG interpretation (to be assessed by supervising faculty)
Successful completion of all of the above required procedures is expected for promotion to PGY-2 status and is required July 1st, of the second year of training. Any resident who has not met this requirement may be asked to complete additional remedial time at a PGY-1 level to complete these procedures and may have to extend their overall training dates as a result. Inability to complete all required procedures in a timely fashion during a remediation period may be grounds for non-promotion to PGY-2 status. *PCTT residents do not have the same amount of inpatient rotations allowing access to procedures so this may not be met and this will be taken into consideration. PCTT PGY1’s are still strongly encouraged to get these done.

C. PRIVILEGES TO PERFORM PROCEDURES INDEPENDENTLY

In order to perform procedures at a later date without supervision, it is necessary that residents provide documentation of procedural skills. To obtain certification to perform a specific procedure, the resident must:

- Dictate or write notes for all procedures performed at both the VAMC and RRMC. Only one procedure per dictation will be accepted. Improperly documented procedures will be returned.

- Provide a copy of all procedure notes to the program office. It is wise to keep copies for your own files as well.

- Have the supervising physician complete the PROCEDURAL SKILLS ASSESSMENT FORM http://www.medicine.nevada.edu/dept/IMNorth/DocumentandForms.asp on site, evaluating your proficiency and professionalism. This form should be attached to the appropriate procedure note prior to submission to the program office for credit.

- Only procedures that are assessed as “resident is capable of performing this procedure safely and independently” will count towards credentialing at the VAMC and RRMC as a resident; however, all procedures should be submitted to count towards total numbers of procedures performed which is used for credentialing after completion of residency.

- After the resident has performed the minimum number for a procedure, the program director will review all related documents and if everything is in order, “sign-off” that the resident may independently perform and supervise other residents in performing procedure per the specific policies of each of the participating hospitals. As above, these are different at each hospital and specific information is maintained for each hospital documenting what procedures each resident has permission to perform without mandatory bedside supervision.

- When applying for privileges at any hospital, make a written request to the program director for verification of competency.

Please note that this policy exists to smooth the privileging process at medical institutions after graduation from the residency program. It is the resident’s responsibility to monitor and update his/her procedural file in a timely manner.
It is the goal of this program that every resident complete the minimum number of required procedures as outlined by the ABIM in start of PGY-2 year, July 1st for promotion into the PGY-2 training year.

X. CONTINUITY CLINICS

**Categorical residents** in the Internal Medicine Residency program have continuity clinic responsibilities at Renown/UNRMed or VA hospital. Categorical interns will start routine continuity clinics at the beginning of their PGY-1 year within the first 5 weeks. The clinic time is once every 5 weeks with 7 half day clinics in a week, 1 half day for QI, 1 half day for research and 1 half day of team based learning/wellness. The number of patients assigned to each resident’s overall panel and the number of patients scheduled per clinic will increase concomitantly with their level of skill and training. Generally interns have 2-3 patients for the first 6 months, then increase to 3-4. PGY-2’s have 4-5, PGY-3’s have 5-6 per half day.

Continuity clinic patients are the responsibility of each resident, whether the resident is in clinic that day or not. All routine prescribing is the responsibility of the primary assigned resident, as is the timely completion of paperwork, forms, prescription renewals, etc. that patients may need done at irregular intervals. Residents are expected to go to their “in baskets” a minimum of twice per week. Additionally, residents are expected to respond in a timely fashion to calls from the clinic staff as well as patient needs that arise between clinic sessions. If a resident is unable to come to clinic to meet a patient’s needs, they may request that the clinic attending or one of their colleagues fulfill that responsibility. All patient needs will be met by covering physicians while a primary care resident is on scheduled leave or ill. If a patient requires a call from their assigned resident, this must be completed within 48 hours (excluding weekends). All patient interactions of substance (including ALL face-to-face visits and some phone contacts, based on content) must be documented appropriately in the medical record in a timely fashion. At the clinic site, all documentation should take place via EMR.

It is each resident’s responsibility to present to clinic on time to see patients on all scheduled days.

All categorical residents are required to complete a quality assessment of their clinic performance twice yearly under the supervision of the attending clinic physician. Specific goals for improvement will be identified by the resident and attending. During subsequent quality assessments these goals will be reviewed and progress in improvement will be monitored. Time during a clinic session will be set aside to accomplish this task.

Continuity clinic performance is a substantive part of the ACGME internal medicine training requirements and all continuity clinic activities will be formally evaluated by the faculty preceptors twice yearly in addition to informal feedback that will be given as appropriate. Failure to comply with clinic guidelines or substandard performance on any of the ACGME general competencies in the clinic venue can be a basis for remedial action, non-promotion, loss of privileges, or dismissal.
Primary care track trainees (PCTT) will have continuity clinic during their outpatient rotations on HOME BASE, which will be located at the Center for Advanced Medicine B, 1500E. 2nd St. Suite 302.

During HOME BASE, PCTT will have for every five week block a total of roughly 6 clinics per week of primary continuity care with a defined patient population. Clinic hours will be Monday thru Friday, non-holidays from 8 am thru 5 pm. All of the above conditions / expectations and evaluation methods as listed for categorical track residents will apply to PCTT.

Exceptions to the above are as follows:

1. PCTT will attend a specific morning report on population based preventive health each Weds from 8:15 am till 9 am, thus their first morning patients will be scheduled at the latter time for Wednesdays only.

2. PCTT will be assigned to a buddy partner system. That individual whom is assigned to HOME BASE for the block, will have the responsibility of checking his partner’s inbox on EPIC to take care of any patient related requests such as medication refills, review of tests results and patient advice queries regarding explanation of laboratory tests, diagnostic study results or inter-current illness and suggestions for further care.

3. PCTT during HOME BASE will perform the above duty to their best ability recognizing that patient scheduled care takes priority from the hours of 8 am till 4:30 pm.

4. After working hours during regular week days, a PCTT will be assigned to home call and have the ability to access EPIC remotely by computer. This individual will respond to any internet patient advice query after hours not dealt with during working hours and for those submitted to EPIC via MyChart by 8 pm. This also includes weekend coverage and holidays with patient advice queries having to be submitted and answered by 8 pm. After 8 pm, all patient advice queries will roll over to the morning and be addressed during the next work day by each individual whom will also cover his “buddy” or in the case of a weekend/holiday by the next PCTT on home call for that period.

5. After working hours, weekends and holidays, PCTT assigned to home call will maintain a cell phone for non-emergent phone calls from Enhanced Primary Care Practice clients. The exchange will call the PCTT on home call with sufficient information to permit the resident to call a patient back but no PHI will be given to the resident via phone. After making contact with a client, the PCTT on home call can exercise the option to ask for a client’s PHI to allow one to bring up appropriate medical records remotely on EPIC. **GIM faculty are assigned to monthly after hours call assistance to PCT residents whom may wish to contact our exchange (982-5100) in the event they need supervision.**

6. In regards to chart completions, PCTT are expected to make every effort to complete notes during clinic hours but if not, it will be expected that a note be completed by 9 pm
on the evening after a working clinic to allow attendings to sign off the next morning and attest to their supervision.

XI. COMMUNICATION EXPECTATIONS

All residents and attending physicians can be contacted directly via personal cell phone, or by telephoning the answering service at 775-352-5100. Any changes in cell phone number must be promptly communicated to the answering service as well as to the residency program office and department office. If any changes are requested regarding call responsibilities, the department needs to be notified, and proper forms signed by each resident involved and approved by the program director. It is also imperative that the resident contact the answering service to advise them of last-minute changes to the online call schedule. Deviation from the call schedule without appropriate notice and approval is unacceptable and may result in disciplinary action.

All residents are expected to be on Tiger Text at Renown. Resident sign outs should occur between 4:30 - 6 p.m. weekdays, regardless of a resident’s actual departure time; sign outs should always be done with direct contact, in person. In no case is leaving a written list for the on call team acceptable or over the phone sign out. It is the responsibility of the resident to find the call resident. All interns and senior residents must also notify the answering service at 775-352-5100 as soon as they go off duty and are no longer available, such as days off when answering service expects said resident to be working. Sign outs should never occur prior to 4:30 pm M-F; on weekends or holidays, interns and seniors who are not on call may sign out their services at 12:00 pm, once all needed patient care is completed.

An attending physician is available for consultation or to supervise procedures 24 hours a day. The schedule of attending physicians is available at www.amion.com with a password of unsomim. Emergent problems with an attending physician should be discussed immediately with either the chief resident(s) or program director, who are available through the answering service after hours or on weekends.

XII. RESIDENT WORK LOAD AND SUPERVISION

Our policies on limiting resident working hours and on resident supervision are meant to help assure that all patients receive high quality care and that residents receive excellent training. All residents, as well as your faculty, residency director and department chair, are responsible for ensuring that these guidelines are followed.

A. Resident Working Hours

Physicians are expected to have a keen sense of personal responsibility for patient care that is not automatically discharged at any given hour or day. In no instance should the resident go off duty until the proper care and welfare of their patients has been ensured.
The residency program requires work hour reporting per New Innovations for programs review for resident compliance to work hour restrictions.

Specific program rules are as follows:

1. ACGME and UNRMed requirements with regard to resident work hours mandate that residents’ weekly work hours may not exceed 80 hours when averaged over a 4-week period. Clinical work hour exceptions may be granted on certain rotations for up to a maximum of 88 hours.

2. Residents must also have 1 day (i.e. 24 hours) out of 7 off duty when averaged over a 4-week period.

3. Duty periods for all residents may be scheduled for a maximum of 24 hours of continuous duty in the hospital. This must be followed by a 14 hour period of free clinical time. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

4. Residents should use alertness management strategies in the context of patient care responsibilities.

5. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00pm and 8:00 a.m. is encouraged.

6. To ensure effective transitions in patient care, senior residents may be allowed to remain on-site for up to four additional hours.

7. In unusual circumstances residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. These “unusual circumstances” are limited to need for continuity of care of a severely ill or unstable patients, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
   a. During these circumstances, care of all other patients must be handed over to another physician, and appropriate documentation of the reasons for remaining to care for the patient in question must be submitted to the program director. This documentation must occur each time this occurs. This data will be tracked by the program director.

8. Residents may not work more than 12 continuous hours in an emergency room setting.

9. Attending physicians are expected to provide backup if needed so that patient care is not delayed or compromised due to adherence with the above rules.
Meeting the above recommendations will involve a cooperative effort among faculty and house staff. For ward rotations in which more than one resident works on a service, one day per week off duty will be achieved if residents cross-cover for one another. For residents assigned to a service that may have a single trainee responsible for inpatient care (i.e., neurology, cardiology), a weekend day may be taken off by having the attending cover patient care responsibilities. Residents on electives without direct inpatient care responsibilities should have no problem in achieving the above guidelines as set forth by the ACGME.

The number of patients assigned to each PGY-I must permit detailed study and effective management of each patient, and yet ensure that the residents are challenged with diverse and complex problems. A PGY-1 should be responsible for no more than 5 new admissions per admitting day and for the ongoing care of no more than 10 patients; 2 additional patients may be accepted in transfer per 24 hour period. Once a PGY-1 has admitted 5 patients in 24 hours, or 8 in 48 hours, or has 10 patients on his/her service, the senior resident will absorb further admissions until the night float team begins duty. The senior resident may redistribute patients to equalize intern loads in the morning. Whenever possible, PGY-1 residents should continue to be responsible for any patients they personally admit to better maintain continuity of patient care.

A senior resident is expected to care for more patients than a first year resident and will be expected to assume primary care for admissions exceeding the PGY-1’s limit. Senior residents who are supervising more than one intern may be responsible for the care of no more than 20 patients total; patients for whom the senior is only a consultant do not count toward this maximum. If supervising only one or no intern, senior residents may be directly responsible for no more than 14 patients. Senior resident may admit 10 patients in 24 hours or 16 in 48 hours and may accept up to 4 additional patients in 24 hours that are transfers from other inpatient services. Once a senior resident has admitted 10 patients in 24 hours or 16 in 48 hours, they may not be responsible for admitting any additional new patients. At RRMC, the supervising attending should be contacted and the on-call senior resident must notify the ER, the answering service and the program director (voicemail 328-1755) that the University services are closed to additional admissions until the next resident shift. At the VA, the on-call attending physician will be responsible for admitting any patients that come in after a cap is reached.

B. Supervision of Residents

Supervision will be provided for all residents by an attending physician in a manner that is consistent with proper patient care, the educational needs of the individual residents and commensurate with the level of training and experience of the residents. All inpatient teams will conduct teaching/attending rounds in person with supervising faculty daily. Residents are encouraged to seek guidance and assistance from their supervising attending physician whenever they are unsure of how to proceed in patient care activities. Supervision will be provided in a manner that ensures that residents assume progressively increasing responsibility and authority based on their demonstrated level of skill, ability and experience.

Continuity clinic
PGY-1’s – all patients need to be seen by the clinic preceptor for the first 6 months. PGY-2, PGY-3 patients are seen as determined by the preceptor. Patients requiring a higher level of service all need to be seen by the preceptor. All new patients need to be seen by the preceptor all three years.

For PCTT, PGY-1’s need to present and have their patients physically seen by the attending physician for the first 6 months of the year. Following that time frame, PCTT PGY-1’s need only have their preceptor see patients for those whom are new patients to the practice or for whom case complexity and billing demands the presence of an attending physician in the room.

For PCTT, at the PGY-2 and 3 level, the attending physician needs to see a patient only in the circumstances of a patient being new to the clinic or a function of case complexity and billing.

XIII. CAPS and TEMPORARY CLOSURE OF TEACHING SERVICES

The ACGME mandates that senior residents must not be responsible for the admission of more than 10 new patients in a 24-hour period (an additional 4 patients may be accepted in transfer from other inpatient teams); we have limited admissions to 8 per admitting shift due to acuity and overall workloads. The policy for handling closure of the resident service to additional admissions once the cap has been reached at RRMC is as follows:

1. The soft cap of 8 applies to NEW ADMISSIONS only; consults and transfers from other RRMC services do not apply to the caps count. Transfers from other hospitals are considered new admissions.

2. After the on call senior resident gets their 9th admission, the teaching service will closed to all further new admissions until the following day at 0600 or if occurs during the day until night float resident arrives. Soft cap during day is 4-6 admissions depending on intern census with all further admissions being restricted to UHS patients (hard cap with 2 interns is 10 patients). All additional admissions will be handled by the RRMC hospitalist on call.

3. When the on call team caps, the senior resident MUST call
   a. The answering service to let them know that the service is closed to new admissions.
   b. The RRMC ER tell them that the service is closed to additional new admissions.
   c. The senior resident will tell each of these entities that the resident service is capped and closing for any additional admissions until the next resident shift begins. The on-call resident team is still responsible for all patients admitted prior to closure as well as all cross-cover for established inpatients in addition to UHS patient admissions.
4. All patients admitted after a caps closure are the responsibility of and will receive all care from the hospitalist service for the duration of the admission. If a hospitalist feels that a patient should be transferred to the teaching service after a non-teaching admission, such transfer will need to be directly discussed with the teaching attending on call for the day and approved by that attending physician prior to transfer based on assessment of the specifics of that case.

5. At the VAMC, once the on call senior resident has admitted 10 admissions, they need to notify the ER physician and the attending on call of this. All further admissions until 0700 the following day or until night float resident arrives at 7:00pm will be the responsibility of the on-call attending physician.

XIV. POLICY REGARDING CARE OF NON-TEACHING PATIENTS

Internal Medicine residents are not expected to be responsible in any way for the care of patients who are not on the designated teaching services except in the following limited circumstances:

1. There is an appropriate request for an Internal Medicine consultation from the designated attending caring for that patient. In that case, the consulting resident, with assistance and supervision from the supervising attending, should provide any and all care to the patient deemed necessary within the boundaries of the consultation. This may include orders, procedures or even the transfer of the patient to the care of the teaching service. If a service transfer occurs, the original primary attending would assume the role of a consultant on the case, as appropriate. Care plans should be discussed with the designated primary attending prior to institution.

2. A senior resident may respond to an emergency situation involving a non-teaching service patient as a member of the “Code Blue” and/or rapid response teams. ACLS protocol would be followed until the appropriate physician is available to assume the care of the patient or the patient has been stabilized, then the resident would no longer be involved in that patient's care.

3. Simple declaration of death of a non-teaching patient is specifically excluded from the responsibilities of the resident as per the program and departmental policy.

4. While on the VA wards, residents are not to provide cross coverage for the CLC ward except in a code blue or rapid response situation.

XV. TRANSITIONS OF CARE/HANDOFFS POLICY

I. Purpose:
To establish protocol and standards within the University of Nevada, Reno School of Medicine internal medicine residency and fellowship programs to ensure the quality and safety of patient care when transfer of responsibility occurs during duty hour shift changes and other scheduled or unexpected circumstances.

II. Definition:

A handoff is defined as the communication of information to support the transfer of care and the responsibility for a patient/group of patients from one provider to another. Transitions of care are necessary in the hospital setting for various reasons. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another. Transition of care occurs regularly under the following conditions:

- Change in level of patient care, including inpatient admission from an outpatient procedure or diagnostic area or ER and transfer to or from a critical care unit.
- Temporary 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 change, including change of shift for nurses, resident sign-out, and rotation changes for residents.

III. Policy:

Schedules and clinical assignments are designed to maximize the learning experience for residents as well as to ensure quality care and patient safety, and adhere to general institutional policies concerning transitions of patient care.

IV. Procedure:

1) The transition/hand-off process must involve face-to-face interaction with both verbal and written/computerized communication, with opportunity for the receiver of the information to ask questions or clarify specific issues. The transition process should include, at a minimum, the following information in a standardized format that is universal across all services:

   a) Identification of patient, including name, medical record number, and date of birth.
   b) Identification of admitting/primary/supervising physician and contact information
   c) Diagnosis and current status/condition (level of acuity) of patient.
   d) Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken.
   e) Outstanding tasks – what needs to be completed in immediate future?
   f) Outstanding laboratories/studies – what needs follow up during shift?
   g) Changes in patient condition that may occur requiring interventions or contingency plans.
h) The hand-off process may not be conducted by telephone conversation. Voicemail and/or any other unacknowledged message is not an acceptable form of patient hand-off. Patient confidentiality and privacy must be guarded in accordance with HIPAA guidelines.

i) Please follow the sequence and guideline summarized below:

I  Illness Severity: Stable, “watcher,” unstable

P  Patient Summary
   · Summary statement
   · Events leading up to admission
   · Hospital course
   · Ongoing assessment
   · Plan

A  Action List
   · To do list
   · Timeline and ownership

S  Situation Awareness & Contingency Planning
   · Know what’s going on
   · Plan for what might happen

S  Synthesis by Receiver
   · Receiver summarizes what was heard
   · Asks questions
   · Restates key action/to do items

1. Scheduling and transition/hand-off procedures ensure that:
   - Residents comply with specialty specific/institutional duty hour requirements
   - Faculty are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents.
• All parties (including nursing) involved in a particular program and/or transition process have access to one another’s schedules and contact information. All call schedules should be available on department-specific password-protected websites and also with the hospital operators.
• Patients are not inconvenienced or endangered in any way by frequent transitions in their care.
• All parties directly involved in the patient’s care before, during, and after the transition have opportunity for communication, consultation, and clarification of information.
• Safeguards exist for coverage when unexpected changes in patient care may occur due to circumstances such as resident illness, fatigue, or emergency.

2. Residents in the internal medicine program will receive education about and must demonstrate competency in transitions of care and patient hand offs:

• Direct observation of a handoff session by a licensed independent practitioner (LIP)-level clinician familiar with the patient(s)
• Evaluation of written handoff materials by a clinician unfamiliar with the patient(s)
• Residents will receive annual didactic sessions on communication skills including in-person lectures, web-based training, review of curricular materials and/or knowledge assessment
• Assessment of handoff quality in terms of ability to predict overnight events

3. The internal medicine program will monitor the transition of care process to ensure:

• There is a standardized process in place that is routinely followed
• There consistent opportunity for questions
• The necessary materials are available to support the handoff (including, for instance, written sign-out materials, access to electronic clinical information)
• A quiet setting free of interruptions is consistently available, for handoff processes that include face-to-face communication
• Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines
• Monitoring checklists including these items are attached to the end of the policy

XVII. FIT FOR DUTY

I. Purpose:
Fit for duty evaluations are used to determine if a resident/fellow’s performance is being affected by impairment that includes but is not limited to medical, mental health or substance abuse problems. The purpose of the fit for duty evaluation is to determine the resident/fellow’s ability to perform his/her clinical duties and responsibilities safely; meaning that they are not a danger to patients, colleagues or self.

II. Definition:
Fit for duty-in condition appropriate and necessary to fulfill all of the demands of one’s professional obligation.

III. Policy:
Residents must report for program duties well prepared and in physical and mental condition to competently perform their duties.

IV. Procedure:

1. An attending, peer, other personnel working with the resident/fellow or clinical competency committee identifies a resident/fellow as having serious academic or behavioral deficiencies and reports findings to the program director.
2. The program director will discuss the identified issues with the associate dean for graduate medical education/DIO.
3. If it is agreed that a fit for duty evaluation is needed, the resident/fellow may be placed on administrative leave until the evaluation is done.
4. The associate dean for GME/DIO will contact the Employee Assistance Program director or designee who will do an initial interview with the resident/fellow and determine if an additional evaluation is needed.
5. The program director and/or the associate dean for GME/DIO will share the information with the evaluator(s) selected to perform the fit for duty evaluation.
   a. This is not a confidential session between the resident/fellow and a counselor, in that this is considered an academic referral and therefore, will not be subject to the same privacy rules as occurs in a therapeutic relationship.
   b. A report will be generated to inform the program director and the associate dean for GME/DIO if a resident/fellow can safely return to work.
   c. The resident/fellow may be referred to the appropriate professional (physician, masters of social work, psychologist, etc.).
   d. Costs for the evaluation will be addressed at the level of the GME office.
6. If the resident/fellow being evaluated is determined to be fit to return to work, the evaluator will make an effort to contact the associated dean for GME/DIO and/or the program director as soon as that determination is made, which may be prior to writing the report so that scheduling plans can be made for the resident/fellow.
7. If the resident/fellow is identified as not fit for duty, the evaluator will contact the associate dean for GME/DIO and the program director. Notification may take place prior to writing the report in order to plan for the absence of the resident/fellow.
   a. Once the written report is received, the program director in consultation with the associate dean for GME/DIO will determine the status of the resident/fellow in the program.
   b. This could result in termination, medical leave of absence, or personal leave of absence.
   c. In order for reinstatement into a program, a fit for duty report must be submitted to the program director and the associate dean for GME/DIO.
   a. A resident/fellow who continues to be “unfit for duty” after 90 days is in jeopardy of losing his/her position.
2. A resident/fellow who refuses a fit for duty evaluation will not be allowed to work as a resident/fellow and will be terminated from the program.

XVII. FATIGUE MITIGATION

Introduction:

In July 2011 the ACGME introduced new program requirements in a special section titled Resident Duty Hours in the Learning and Working Environment. In section A. – Professionalism, Personal Responsibility and Patient Safety, there are sections describing need to recognize fatigue in him/herself and others as well as be fit for duty (see next policy).

Procedure:
When a resident/fellow identifies him/herself or peers and attending identifies the resident/fellow as being too fatigued to drive home, there are several options for trainees:

1. Call rooms/sleep quarters are available at all facilities for the resident/fellow to use for a nap until the resident/fellow is less fatigued.
2. Public or private transportation if available may be utilized.
3. Peers, attendings, family may be called to assist transporting fatigued trainees to their residence.
4. Program will provide taxi or reimburse for it after the above options have been exhausted.

XVIII. CONSENSUAL RELATIONSHIPS

I. Purpose:
As outlined in the University of Nevada – Reno’s consensual relationships policy, UNRMed is committed to maintaining learning and work environments as free as possible from conflict of interest, exploitation, and favoritism. The supervisor-learner relationship represents a special circumstance because maintaining and protecting the integrity of this relationship is of fundamental importance to the central mission of the University.

Policy:
1. In cases where one person uses a position of authority to induce another person to enter into a romantic and/or sexual relationship, the likely harm to the induced person and to the institution is clear.
2. Even in cases where the relationship is deemed “consensual” by the involved parties, significant potential for harm remains when there is an institutional power differential between them.
3. The existence of such relationships may cast doubt on the objectivity of any supervision and evaluation provided.

4. Even allegedly “consensual” relationships that occur in the context of educational supervision and evaluation can give rise to serious ethical concerns and present significant conflicts of interest.

5. Therefore, it is the policy of the Department of Graduate Medical Education that individuals in a position of authority, defined as those who teach, evaluate, supervise or advise learners, shall not engage in consensual relations with them.

XIX. TERM OF RESIDENCY

The duration of the categorical residency in internal medicine is considered to be a total of 36 months of training and for the preliminary year, 12 months. During this period, a resident is allowed vacation and educational leave as outlined above. If a resident cannot honor his time commitment he must notify the program director in a timely and appropriate fashion or risk an unsatisfactory evaluation in professional attitudes and behavior or overall performance.

XX. MOONLIGHTING

Moonlighting is permitted during residency for PGY-2 and PGY-3 residents as a licensing board permits and requires approval of the program director. A work week including moonlighting cannot exceed the 80 hours.

XXI. MEDICAL RECORDS

Appropriate chart documentation and prompt completion of medical records is instrumental to good medical care and communication. The following applies to all inpatient services.

1. Prior to a patient's discharge, a complete hospital summary must be completed by the senior resident. In addition, a short note must be in the chart addressing the discharge diagnoses and follow-up in the event the patient returns before the final typed summary is available.

2. Residents should sign electronic records regularly and check weekly to determine if dictations need completion or correction or if verbal orders need to be signed. Medical records departments require at least 6 hours’ advance notice in order to pull physical charts if necessary.

3. Residents who have chart delinquencies will be notified and are expected to:
   a. Complete any dictations and/or signatures of delinquent charts within 48 hours of notification. Exceptions to this rule may occur when the chief of service at the VAMC deems an immediate dictation be done because of patient transfer or for quality assurance reasons.
b. Failure to comply with the above may result in suspension of clinical privileges, cancellation of vacation, graduation or promotion, probation, dismissal from the program or an unsatisfactory evaluation in professionalism.

XXII. QUALITY ASSURANCE

Quality assurance protocols are available at clinics and hospitals in which residents train. Resident participation is encouraged in quality assurance activities at each training hospital (RRMC and VAMC). These committees review mortalities as well as any patient management concerns.

Residents on medical ward/ICU services the previous month are also mandated to attend monthly Morbidity and Mortality conferences to discuss outcomes during their month on service. These meetings are generally held monthly during scheduled noon conferences with the Chief Residents, faculty and Program Director in attendance.

A. Veterans Affairs Medical Center (VAMC)

The Quality Management Service is responsible for the hospital adhering to Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. The service incorporates quality assessment, utilization review, risk management, safety, infection control, and privileging and credentialing.

In addition to the Chief, ext. 1709, the Service includes three quality assurance/utilization review (QA/UR) screeners who do concurrent reviews for proper utilization of services and quality of care. Each clinical bed service has a QA committee where opportunities to improve care are discussed. Residents are encouraged to attend these meetings to learn about the QA/UR process that they will need to function under in private practice.

B. Renown Regional Medical Center (RRMC)

At Renown Regional Medical Center, residents are re-appointed each June. This reappointment consists of a recommendation by the residency director, the clinical department, the Credentials & Privileges Committee, the Executive Committee, and the Board of Governors of the medical center. This reappointment is designed to evaluate the quality of all residents on a yearly basis. Patient care at RRMC is reviewed by the appropriate services in adherence with Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

XXIII. RESIDENT PHYSICIANS’ COMPLAINT / GRIEVANCE PROCEDURES

The procedure below is intended to assure that a resident's complaint or grievance is given appropriate attention. This should not be confused with the separate documents describing the resident's right to due process. Due process procedures are to be followed when a resident
requests formal review of an action taken against the resident. If, however, the resident has a complaint about working conditions, poor treatment by a hospital employee, etc., and the resident's attempts to resolve the complaint through normal channels have failed, then the procedure below should be followed.

If a resident has a complaint or grievance, it should be discussed first with the program director and then the department chairman. If the resident feels the complaint or grievance has not been satisfactorily addressed, they should contact, in writing or by phone:

Dr. Dave Carlson  
Associate Dean for Graduate Medical Education  
University of Nevada, Reno School of Medicine  
745 W. Moana  
Reno, Nevada  89509

DUE PROCESS
Refer to the attached “UNRMed Resident Physician, and Fellow Handbook of Policies and Procedures”.

XXIV. RESIDENT ELIGIBILITY AND SELECTION

Please see the University Of Nevada, Reno, School Of Medicine Resident Physicians and Fellows Handbook of Policies and Procedures under “Resident Eligibility and Selection” for the comprehensive University of Nevada School of Medicine recruitment policies.

The University of Nevada (Reno) internal medicine residency accepts applications through the Electronic Residency Application System (ERAS) only and cannot accept applications in any other format. Documents submitted separately by mail, email or fax will not be considered as part of an applicant’s file. A complete application consists of the standard ERAS application package as well as related supporting documents including:

- Dean’s Letter (MSPE) or equivalent
- Medical school transcript
- A minimum of 3 letters of recommendation
- Detailed education and work history
- Personal statement
- USMLE or COMLEX transcripts
- Passport-sized color photograph
- ECFMG certificate (if applicable).

While we will begin screening applications for interview prior to receipt of all of the above elements, we are not able to rank any candidate for the Match until all required elements have been received for review. Applications are accepted and reviewed from mid-September through mid-November, and interviews are conducted from early to mid-November through early January each academic year. Applications are screened as they are received, and those
candidates meeting interview criteria are sent invitations, generally via email, as soon as their applications have been reviewed and processed. Interview dates are available to invited candidates on a first come, first served basis. We maintain a cancellation/waiting list for all dates and can sometimes accommodate requests for dates previously filled, if space subsequently becomes available.

Our National Residency Match Program (NRMP) identification numbers are:

**Categorical Internal Medicine: 2017140C0**  
**Preliminary Internal Medicine: 2017140P0**  
**Primary Care Track: 2017140M0**

We currently accept 20 categorical and 4 preliminary interns each year.  
For the Primary Care Track, we accept five PGY-1s per year via NRMP match.

**Eligibility Criteria**

All candidates must successfully complete USMLE Step I and both USMLE Step II CK AND CS to be eligible to enroll in the residency program. While applicants who have not completed Step II at the time of interview will still receive consideration, completion of both Step II elements prior to the Match ranking deadline is strongly recommended, and is mandatory prior to hire. COMLEX Level 1, Level 2 CE and Level 2 PE tests are accepted in lieu of USMLE for DO candidates.

Scores for all USMLE and COMLEX exams must be at minimum: “PASS”. Preference is given to candidates who have completed medical training within the past 5 years.

For international medical graduates, U.S. clinical experience is required as are U.S. letters of recommendation. This residency program is only able to consider U.S. citizens and U.S. permanent residents with green cards. The program will consider J-1 visa candidates on a limited basis.

All information received is considered and we will review otherwise strong candidates who do not meet all the above criteria at the program director’s discretion.

The University of Nevada does not discriminate in admissions, educational programs, or employment against any individual based on gender, race, color, religion, age, disability, veteran status, national, or ethnic origin, and is committed to affirmative action and equal opportunity.
XXV. MISCELLANEOUS

The following are referenced in the School of Medicine policies in the “UNRMed Resident Physician, and Fellow Handbook of Policies and Procedures” in this volume, and/or in the Resident Employee Contract:

A. Sick Leave (see section II. on procedure)
B. Parental Leave/Family Leave
C. Leave of Absence
D. Jury Duty
E. Professional Liability and Health & Disability Insurance
F. Military Leave
G. Away Electives

Away electives are a privilege extended under special circumstances to meet goals in alignment with the overall residency program educational goals. Therefore, to be considered for an away elective, a resident must be in excellent academic and professional standing as demonstrated by criteria outlined below. Only one 4-week elective may be spent away from the program during the last two years of residency; PGY-1 residents are not permitted to take away electives. Additionally, the resident is responsible for setting educational goals and preparing paperwork related to the rotation. Away electives will only be approved for rotations within internal medicine and its subspecialties. Because of the stringent requirements, it is recommended that any resident considering application for an away elective should first meet with the program director to discuss whether he or she is eligible to apply.

Goals for away electives:
   · Audition for a fellowship
   · Participate in research
   · Subspecialties not offered at UNRMed

To be eligible for an away elective, a resident must:
1. Have at least 60% attendance at noon conference
2. Have all patient documentation up to date
3. Be up to date on all other administrative paperwork
4. Take and pass all mini-exams
5. Score at the 45 percentile rank for first year, 55 percentile rank for second year.

After determining with the program director that a resident is eligible to apply, they must:
1. Define the goals and the educational objectives for the away rotation.
2. Submit goals and objectives to the program director for approval to obtain a PD letter of support.
3. Contact the GME office to obtain paperwork regarding affiliation agreements, malpractice coverage, etc.

Considerations:
Approval is always at the discretion of the program director; being eligible to apply does not imply that you will be approved for an away elective. Approval will **always** depend on availability of funds to support this activity. To allow for completion of required paperwork necessary for an away elective, you must begin planning at least four months in advance. The GME office requires **at least three months** for the processing of their portion of the application.

H. OTHER

1. Overnight call quarters with bathroom facilities are provided at both VAMC and RRMC. Any problems with the cleanliness or security of the call rooms must be reported to the chief resident or program director immediately so that any problems are solved expeditiously.

2. Meals are provided at no charge to residents on call at the VAMC as follows:
   a. Monday-Friday: evening meal, breakfast the following day
   b. Saturday-Sunday: lunch, dinner, breakfast the following day (see meal ordering protocol in appendix).

3. RRMC provides on-call meals for residents who are assigned to that location on rotation. Monday through Friday, breakfast and lunch meals are available at no charge in the Physician’s Dining Room. Meals for other periods are available in the cafeteria. Residents are allotted $5 per meal for any meals that are provided in that setting. Food (sandwiches, snacks, drinks, etc.) may be available in the physician’s lounge at no charge.

4. Locker space is provided at the VAMC (located near call rooms) and at RRMC (in the resident conference room near the internal medicine offices).

5. All residents will also be provided with user ID and passwords for access to their UNSOM e-mail accounts and to the Savitt Medical Library, both on campus and on the internet. **Residents must check their university email daily at minimum.**

6. Confidential counseling and psychological support services are available to residents; please see the appropriate section in the UNSOM “Resident Physician and Fellow Handbook of Policies and Procedures”

6. Laundry of call room linens at RRMC and VAMC is provided.
Appendix A

Graduation Check List:

All Years:
1) Noon conference attendance yearly at 60% (clock in time 11:45-12:10)
2) Completion and passing of all Mini Exams yearly
3) Quality Improvement(QI) team project yearly
4) John’s Hopkins modules 10/year – ambulatory didactics
5) Duty hours completed by the last day of every month
6) All evaluations completed in a timely manner

PGY1
1) Step 3 of the boards passed
2) 10 QI and Patient Safety(PS) modules Institute of Healthcare Improvement (IHI)
3) Completion of required procedures
4) Quality Improvement team project (participant)
5) PCT group research project (participant)

PGY2
1) 6 QI and PS modules (IHI)
2) Quality Improvement team project (contributor)
3) Team Research/Scholarly Project
4) Team Research/Scholarly Project Presentation

PGY 3
1) Individual scholarly project to Graduate – i.e. Goodman competition, ACP poster, resident research day, case report, literature review
2) 5 modules on Person and Family Centered Care (IHI)
3) One - Group inpatient QI
4) Quality Improvement team project (project leader)
5) Team Research/Scholarly Project
6) Team Research/Scholarly Project Presentation
Appendix B:  
VAMC Standard Work Flow on Wards/ICU

Night float distribution at the VAMC is responsibility of senior.

VA Night Float (NF) will admit from 0600pm-0600am. The NF will distribute patients as such:

1) If the Long Call (LC) team did NOT receive 6 new patients (or 3 and 3 H&Ps), then NF will admit patients to that team to reach a goal of 6 new patients for the day's LC team.
2) If the LC team did receive 6 new patients during their call time, then NF will admit round robin, but protect the next day's LC interns.
3) The current day's Long Call is not-exempt from night float, and can still receive patients via round robin EVEN IF THEY ADMITTED 6 TO THEIR TEAM DURING THE DAY. Otherwise, only one team can get admits from nights, which defeats the purpose. The rule of no more than 7 new patients per each individual intern in 24 hours from ACGME must uphold however.

   The NF will avoid giving any non-call intern more than 2 patients.  
The next day's LC "Protection" only applies to NF admissions.  
Short call (SC) is not protected from night float

"Round Robin" is defined as 3a --> 4a --> 5a --> 3b --> 4b --> 5b -The LC and NF seniors will internally keep track of where they are at with the Round Robin.

If there is a difficult situation in which the Night Float Senior needs higher-level assistance, OR if this is a CODE BLUE/Rapid Response, then the Night Float Senior is expected to notify the On Call VA Night Attending (typically this is extension x5211).

**VA Patient distribution for the On-Call Teams:**

1. **Long Call protection removal for admissions:** After thorough review and discussion amongst the UNR program directors, and our colleagues, it appears that we collectively have decided to remove protection to the long call team from getting overnight admissions the night before they will be on long call. This will be effective since (12/15/2017). No team is "protected" from Round Robin. The overnight admissions from the night BEFORE the long call day do NOT count towards the admissions long call day cap [*only admissions done by the LC team itself count in this regard].

2. **Long call is 6:00am-6:00pm.** If the admitting team (Day Long Call or Night Float) has hit 10 patients, the plan is to have the admitting team place holding orders as a good temporary measure for short durations. In the event of multiple patients waiting or longer durations to be anticipated,
the plan will be to have the Backup-Senior come and assist, not the attending physician as it was in the past.

3. **A Long Call Super Team (LC)** is defined as one senior resident with both interns on the same ward team admitting patients and seeing consults, every 3rd day, from 600am-600pm. The Long Call must take admissions up to 6:00pm, and avoid "saving admissions for Night Float". The Long Call senior is never resident-intern with this design, which should make the senior a true supervisor and do less intern work. • The goal is for the LC team to admit 5 patients to their own team prior to distributing patients in Round Robin fashion (defined below), to evenly distribute patients amongst the 3 ward teams. Round Robin will start after the color/team of the last H&P intern of the LC team. • The LC team can admit a total up to 10 new patients during their LC call time. (First 5 to their team, last 5 via Round Robin). • As above, once 10 patients are reached, then holding orders are to be placed for any patients beyond 10. If timeliness of patient care becomes a concern, then Backup-Senior will be called in to do any admissions beyond the 10th admission. • See below for ICU transfers.

4. **A Short Call (SC) team** of (1 senior + 1 intern of the same SC team) will help the Long Call team by taking the FIRST THREE ADMISSIONS or CONSULTS during the 11-3pm. Short Call senior and intern will cover the 12-1pm "ER Witching Hour" and they are exempt from Noon Conference. This will also uphold the ACGME "no more than 8 H&Ps in a 48 hour time period". • The Short Call team admits patients to THEIR OWN TEAM, not via Round Robin. The goal for all this redesign is to have teams ideally admit to themselves as much as possible. • Consults do not count towards caps per ACGME, but they do count towards the number of "admissions" during this time frame.

5. **Night Float (NF) will admit from 6:00pm-6:00am.** The NF will distribute patients as below: • If the LC team did NOT receive 5 new patients (or 5 H&Ps), then NF will admit patients to that LC team to reach a goal of 5 new patients for the day's LC team. • If the LC team did receive 5 new patients during their call time, then NF will admit round robin. ***no protection applies to the next day's LC team or the current day's LC team*** • The rule of no more than 7 new patients (5 H&P + 2 ICU transfers) per each individual intern in 24 hours from ACGME must uphold however. • The NF will try to avoid giving any non-call intern more than 2 patients.

6. "**Round Robin**" is defined as below • Red (V3a) --> Platinum (V4a) --> Bronze (V5a) --> Yellow (V3b) --> Silver (V4b) --> Teal (V5b) • The LC and NF seniors will internally keep track of where they are at with the Round Robin, which should always start after the last H&P of intern from the LC team.

7. **Amion scheduling.** LC will cover from 6am-6pm. This senior carries the "non-ICU admission pager" from 600am-600pm, but will hand this off to the SC senior from 11:00am-3:00pm. • Though both interns will be on call with the LC senior on the same day, the "VA Wards Intern" will cover the classic "intern-on-call pager". • SC will cover the first 3 admissions/consults from 11-3pm, and will cover the 12-1 witching hour
8. **Weekends and Federal Holidays**: Long call on the weekend/holiday will have BOTH interns. There is no Short Call on these days.

9. **ICU transfers**
   - The first 2 ICU transfers are to be sent to the NON-SC/NON-LC call team, one per intern ideally.
   - The next 2 ICU transfers would go to the SC call team (on weekends, the team that would have been SC as if it were a weekday), one per intern ideally.
   - This cycle would repeat at the 5th ICU transfer of that day. Any intern should not receive more than 2 ICU transfers in any given day.
   - We should avoid giving ICU transfers to the LC team, other than bounce-backs.
   - Transfers are not counted as H&P or admissions.

10. **Bounce back rule:**
    - As it always has been a bounce back follows the PGY-1 ONLY for the duration of their contiguous ward rotation, unless it is the 2 senior team in which case it follows the senior whom was taking care of that patient. This is inclusive of patients whom were initially on the medical service, then gets transferred to the psychiatry floor, the surgical service, or ICU team.
    - Bounce backs will not go back to teams that are already capped. Keep in mind that this is a SOFT census cap (i.e. 16 patients total for the 3 resident team, and 12 patients for the 2 senior team) … UNLESS the attending or resident strongly prefers to obtain that patient back (which is ok as the ACGME team caps are still 20 per ward teams with 2 PGY-1s and 1 senior resident).

11. **Consult rule:**
    - Consults do NOT COUNT toward an intern’s patient census. That being said, consults should be followed by the admitting team, as would be a newly admitted patient.
    - Consults on patients that came from medical service: If a patient was on medical service then gets transferred to another service (inpatient psychiatry or surgical service), that medical team who saw that patient will be delegated to see that patient IF the receiving (psych/surgery) service wants to consult medical service. This will improve continuity of care. The exception is if the resident team is no longer on ward service, then it will go to the long call team.
    - Overnight consults: Those consults done by the night float team will be given to the long-call team coming on in the morning.
Appendix C:
RRMC WARD: Standard Work Flow Wards/ICU

1. Morning report
   1. Morning report is 8-9am every Monday-Friday, except Grand Rounds at 7:30am
   2. There will be a monthly simulation morning report in the Sim Lab at RRMC.
   3. Morning report assignments will be done by chief residents on monthly basis.
   4. Grand rounds are mandatory for all staff regardless of call day.
   5. Residents are expected to be ready to present in morning report sharp at 8 AM.
   6. Senior resident is expected to present a summary of current Evidence based medicine (EBM) concepts on the topic discussed in morning report.

2. Day admissions
   1. Each ward team will comprise of 2 interns, 1 senior resident, 1 attending and some medical students. Soft cap for each team is 16. This can go up to 19 with one spot reserved for emergency admits based on attending’s decision. Hard ACGME cap is 20 patients.
   2. The soft cap is 4 for new admissions during the day call (6AM to 6 PM). Hard cap is 10.
   3. Patients will be admitted to the on call team. Each intern on call will take alternate admissions. Senior residents will be responsible to balance the team census and workload.
   4. Total census soft cap for a team is 16 patients. If a team caps at 16, and has not admitted 4 patients for that call day, it is permitted to go up your cap up to 19 patients with your attending’s permission. If a census of 16 or 19 is met based on attending’s decision, senior resident is responsible to inform ER of your cap situation and stop admitting any new patients. Exceptions to this can be made for UNR-Med patients as long as Hard ACGME cap is not violated.
   5. Seniors please send short email to imwards1@medicine.nevada.edu about the call day. The email should include time of admits, initial dx and name, and should not take more than 5 minutes of your time. This does not replace your IPASS sign out or vice-versa.

3. Night float admissions
   1. Designate the team on call for following day as protected. This team only receives patients if there are no other spots available. No admissions can be denied at night as long as we have spots in our teams. The cap is 8 per intern or 16 per team.
   2. If Day call team admitted less than four patients, admissions go to the day call team until they have received four new patients on their census or are capped, and the
remaining admits are distributed one patient each to the remaining teams in ascending order of their census, skipping the protected and capped teams.

3. If Day call team admitted four or more patients, give the first patient to the team with the lowest census, then distribute one patient each to the remaining teams in ascending order of their census, skipping the protected and capped teams.

4. If Day call team admitted four patients but one or more admits went to other teams (ICU or bounce back,) admissions go to the day call team until they have received four new patients on their census or are capped, and the remaining admits are distributed one patient each to the remaining teams in ascending order of their census, skipping the protected and capped teams.

5. After all non-protected teams have received one patient, then start over with the team that started with the lowest census.

4. ICU distribution of patients to medical floor is based on senior census and bounce backs
   1. First two transfer goes to the on call team. If there is no space on that team then the patient goes to non-call team based on their census.
   2. Bounce backs take precedence over transfer order, but counts as a transfer (i.e. if the 3rd transfer team got a bounce back, the team is skipped over and it would go to the 4th team)
   3. Each non call team gets a transfer based on their census in ascending order. Senior residents on team is responsible to balance the census and workload of interns on that team.

5. ICU admissions/census
   1. Soft cap is 14 for ICU team (2 senior and one intern). Each senior if needed on weekends and days off can see up to 14 patients per day. A census is 14 patients is per senior averaged over 7 days. This means that you can see more than 14 once a week when other senior is off.
   2. If you feel that you cannot take care of over 14 patients then discuss with attending that he or she only sees those patients
   3. The soft cap may be exceeded when there are 14 on census and there are additional floor transfers to the ICU, bounce backs, or UHS patients.
   4. ICU night senior’s cap for new admissions is 8 per night. This is a soft cap and go up to 10 patients in the event of unexpected UNR-med admits.
   5. A member of ICU team is expected to be available at all times except for Saturday night when the floor team will cross cover ICU nights.
   6. ICU team is expected to be a closed system and formal verbal transfer in and transfer out process is expected between resident teams.
   7. ICU transfer out list will be created and maintained by the ICU night senior. This senior will be responsible to correctly assign physically transferred out patients to
respective floor team based on the algorithm described above. It is the responsibility of ICU team to ensure that the ward team is aware of the transfer out.

8. Transfer in to the ICU has to be verbally discussed with the ICU attending and senior ICU resident before the transfer by the ward senior/intern.

6. Procedures
1. All procedures must be authorized by the attending
2. All internal medicine procedures may be performed independently if the senior has been signed off by the program, but this must be approved by the attending
3. Interns are never signed off, no matter how many procedures they have done
4. Intubations are not an internal medicine procedure and may never be performed independently
5. Whether you are signed off or not is determined by the program, not based on your own count.
6. Signoffs are uploaded onto an online database that is verified by nursing staff prior to starting the procedure. If a nurse does not believe that you can do the procedure independently and you feel there is a discrepancy, have him/her speak to the nursing manager, who will then verify your certification with the online database.

7. General Rules
1. The senior can admit up to 10 patients for the day (actual H&Ps).
2. If more than 10 admissions, then the attending needs to see the patient(s) or senior can write skeleton/stabilizing admission orders and have night float/next day’s on call senior do full admission of patient.
3. The soft cap during the day is 4 patients and 8 patients for night float. After soft cap, only admit UNR-Med patients or bounce back patients. If the census is low more than 4 can be admitted during the day.
4. Once 64 patients are on the medical ward census, we will only admit UNR-MED patients or bounce backs*. Night float should monitor census for late discharges or patients leaving AMA.
5. If an intern team has more than 8 patients in the morning, a lateral transfer may be made to the other intern. If there are more than 16 patients, then the patients over the cap are assigned to interns/senior based on attendings decision.
6. The on call intern can admit 5 patients by writing H&P. An additional 2 patients can be put on the intern’s team including ICU transfers or patients admitted by senior on-call or night float.
7. Bounce backs within 30 days of discharge will be considered equal to UHS patients. Order of return of patient is #1 intern, #2 senior. Admit back to attending if seen within last 3 days (such as near switch days). If none of the above then all teams are fair game
8. All daily notes and H&P’s must be completed on all patients prior to leaving Renown at the end of your shift
8. Duty Hours
1. An intern may not work more than 80 hours within 7 days
2. An intern may not be in the hospital for more than 24 hours consecutively without a break
3. A break should be at least 10 hours, but minimally an intern is not allowed to return to the hospital until 8 hours have elapsed.
4. Each resident must have one day off a week averaged out over the duration of his/her rotation.
5. The senior is responsible for managing and distributing the overall workload so that interns do not have duty hour violations.
6. If the senior feels that he/she has done everything possible but the intern is still violating duty hours, the chief resident and/or program director must be alerted.

9. ER expectations and flow of work for Night Float
1. UNR- Med, Internal Medicine Resident team will notify ER physicians/clerks on number of spots they have on their team every night.
2. ACGME strictly regulates teaching team caps and as a program we have implemented our cap system so that we do not break any ACGME mandates.
3. Total Cap /night i.e. maximum residents can admit on Wards: 8/night with 2 additional spots as a cushion for UNR-Med patients. This excludes ICU admits except for Saturday night. **Saturday night total cap is 6, which also includes ICU admits.** We have only one team which covers ICU and Floors on Saturdays, hence the change. **On other nights there is a separate ICU resident who can admit up to 8 patients/night for ICU.**
4. Resident physicians are expected to be in ER within 15 minutes of being called for an admit by ER physicians. They are also expected to be in contact with ER physicians and ER clerk on their caps and available slots regularly.
5. Resident team is expected to admit and fill UNR-Med spots first until they cap. UNR-Med can accommodate up to a total census of **64 patients in Wards** and **14 patients in ICU.**
6. ER team is expected to provide 4 patients before midnight and 4 after midnight to avoid boluses.
7. ER clerk is expected to update ER census board with available slots in UNR-Med teams so that ER physicians are aware of that. This will provide an effective way to monitor the system and resident behavior.

10. Expectations of the resident on night float
1. Residents are to receive admissions directly from the ER doctor.
2. If the resident fills up all the UNSOM team spots and has admitted 8 unassigned patients then they are capped.
3. If additional patients that are primary UNR-Med patients need admitting the Sr. Resident can admit beyond the 8 patients. Additional UNR-Med patients will go above the cap of 8 per intern on day teams (this will be rare and 8 is a soft cap).

11. Handoffs
- IPASS Handoff system will be implemented for safe transition of care.
- Residents are expected to provide both verbal and written Handoff during transition of care.
- Written Handoff is completed by intern on service but is supervised by the senior residents. It is the senior residents responsibility to ensure clarity and accuracy of this document.
- Handoff times are: 6 AM in the morning and 6 PM in the evening.
- One resident from the non-call team stays back to sign off to the Night float team. Every member of the Night float team (senior and interns) are expected to be present to receive handoff.
- Night Float team (senior and interns) handoff to the Day teams. This is expected to happen as a team where all members are present.
- Written handoff document is expected to be started by the night float team and updated by the day team. Similarly day team on call is expected to provide a complete written handoff to the night float team.
- All residents will be trained on IPASS system.
- Monitoring of both written and verbal handoff will be done on regular basis by attendings and/or chief residents.
- Follow these basic principles and refer to transition of care section in this document and IPASS bundle in your resident drive for more information:
  - Structured Verbal Handoff
    - Begin with overview of entire service
    - Need proper environment – limit interruptions
    - Use IPASS mnemonic
    - Employ closed loop communication
  - Printed Handoff Document
    - Supplements verbal handoff
    - May import elements from EMR
    - Keeps information current with updates
  - High Level Skills
    - Patient Summary
      - Be concise and focused
      - Establish working diagnosis
      - Include semantic qualifiers
      - Ensure check-back with receiver
    - Contingency Plans – “If this happens, then…”
      - Problem solve before things go wrong
      - Know potential therapies or interventions
      - Identify most worrisome patients
Statement of Understanding

I have received a copy of and understand that I am responsible for knowing the content of the University of Nevada, Reno School of Medicine Internal Medicine, Reno, Residency Manual, and the attached University of Nevada School of Medicine Resident Physician and Fellow Handbook of Policies and Procedures. I understand that any violations of policies herein may be considered grounds for disciplinary action, including suspension, probation, non-promotion or dismissal from the program.

______________________________
Resident signature

______________________________
Date