PART IV

Department of Medicine

Internal Medicine Residency Program

Interns and Residents

2018 – 2019

Updated 7.18

DEPARTMENT OF MEDICINE
INTERNAL MEDICINE RESIDENCY PROGRAM

Policies and Procedures Manual

TABLE OF CONTENTS

Definition and Scope of Specialty

Definition

"Internal Medicine is the discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age during health and all stages of illness. Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence-based decision-making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values." (Program Requirements for Residency Education in Internal Medicine). Tower Health's Internal Medicine Training Program assures competence of its graduates who wish to practice general internal medicine in the ambulatory setting, inpatient setting, or both. The Program offers an opportunity to develop areas of special interest within the field of general internal medicine, and can also fully prepare the resident for ongoing training in a medical subspecialty. The Program assures competence appropriate to the internist in the areas of Patient Care and Procedures, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practice-Based Learning and Improvement, and Systems-Based Practice.

Educational Standards

Competency requirements are adapted from the standards defined by the Accreditation Council on Graduate Medical Education (ACGME). (For further details refer to http://www.acgme.org/outcome/comp/compHome.asp.) The tiered format of goals has been adapted from the RIME framework created by Louis Pangaro, MD, and can be found in his article "Evaluating Professional Growth: A New Vocabulary and Other Innovations for Improving the Descriptive Evaluation of Students," Academic Medicine 74: 1203-7, 1999.

Program Goals and Objectives

Patient Care and Procedures - Intern

The Intern is expected to communicate effectively, demonstrate caring and respectful behaviors when interacting with patients and their families, gather essential and accurate information about their patients. He/she is expected to assimilate this information to produce a complete and thorough history and physical exam, as well as be able to reproduce the information in full oral presentations, quick rounds "synopses" of the relevant features of the case, and directed, organ-system-based presentations relevant to consultants' interests.

The intern should begin **practicing** the skills needed to include the patient and his/her beliefs, individual interests, and desires into a comprehensive plan of care. He/she should develop a comfort level with the counseling skills necessary to educate patients on services aimed at preventing health problems or maintaining health, including immunizations, colon, breast, prostate, and cervical cancers, diet and exercise and healthy lifestyle initiatives. He/she should become comfortable incorporating the patient's value system into the plan of care.

The intern should **master** basic procedural skills, to include introducing intravenous catheters, obtaining arterial blood gases, inserting nasogastric tubes, and **practice** interpreting basic internal medicine tests, including EKG, chest X-ray, urinalysis, and pulmonary function tests. Cognitive competency will be established during on-line sessions and during orientation for arthrocentesis, lumbar puncture, abdominal paracentesis, obtaining arterial blood gases, incision and drainage of an abscess, and IV line placement. The intern will also demonstrate capacity in the proper technique for IV line placement, obtaining femoral arterial blood gas, joint aspiration and pelvic examination through simulation and models during orientation. The intern will also demonstrate technical skill in performing lumbar puncture through use of models. Cognitive and simulation competence for central lines will occur during the ICU rotation.

The intern should **practice** the skills of educating family members of various ages and education levels at the level needed to convey diagnoses, develop care plans, and discussing end-of-life plans and wishes.

The intern should be **introduced** and begin to **practice** the formulation of clinically relevant questions. The intern should develop the skills to locate the most up-to-date scientific evidence, and should **practice** applying that evidence to the unique facet of his/her patient's case. The intern should **practice** skills in collecting and critically appraising data collected in regard to his/her patients. These concepts will have been **introduced** in the AM report, where data searches are frequently modeled in response to questions raised by presented cases. He/she should also be able to understand and discuss the strengths and weaknesses of data, by study type generally and study design specifically. These concepts are **introduced** in monthly journal club, but will be **practiced** in patient care situations as the need arises.

Patient Care and Procedures – Resident

The PGY2 resident is expected to achieve **mastery** in communicating effectively, and in caring and respectful behaviors when interacting with patients and their families. The resident should develop a comfort level in orchestrating large family discussions and coordinating subspecialty and consultant participation in those discussions. While they may occasionally be responsible for complete histories and physicals as the admitting officers of the day, they should **master** the skills needed to develop directed notes and plans devoid of non-pertinent information. They should be able to discuss on paper and in oral presentations a thorough understanding of the acute problems while assimilating the relevant past history and laboratory data to formulate a plan of action and a rationale regarding their selection of that plan. They should be able to critically evaluate the history and physical exam findings of the students and interns on their service by their third year, and should begin to **practice** delivering constructive feedback to their students. They should **master** the coordination of multiple subspecialists in the care of their patients, including calling that consultant with a specific question and presenting a concise, organ-system-based presentation of the problem identified.

The PGY2 resident should develop **mastery** of coordinating care of multiple disciplines, specialties, and ancillary services, and orchestrate final plans in accordance with the patient's wishes. He/she should **practice** dealing with more difficult family issues, and incongruent patient/family wishes, as well as **practice** counseling patients and families following medical mistakes and other legal issues. (This is introduced in our lecture series and our OSCE series.)

The PGY3 resident should develop a **mastery** of the skills needed to include the patient and his/her beliefs, individual interests, and desires into a comprehensive plan of care. The resident should **practice** coordination of care of difficult family situations, incongruent family expectations of care, and discussion of medical errors and unforeseen adverse events. (These concepts are **introduced** at the Intern OSCE evaluation and during legal and ethical conferences during the noon conference series.) The resident should develop a comfort level with the counseling skills necessary to educate patients on services aimed at preventing health problems or maintaining health, including immunizations, colon, breast, prostate, and cervical cancers, diet, and exercise and healthy lifestyle initiatives. The resident should become comfortable incorporating the patient's value system into the plan of care, and should develop a **mastery** of the risks and benefits of applying these preventive services to unusual situations, including patients with limited life expectancy, wards of the state, and patients with limits in their understanding of the risks and benefits of screening. The resident should **practice** skills needed to teach these concepts to his/her ward team effectively.

The PGY2 resident should develop **mastery** in interpreting basic internal medicine tests, including EKG, chest X-ray, urinalysis and pulmonary function tests, as well as arthrocentesis procedure. The PGY3 resident may develop **mastery** of the advanced procedures (thoracentesis, paracentesis, lumbar puncture, central venous catheter placement as appropriate for their future professional needs) to include an understanding of the procedures with sufficient depth to facilitate teaching other housestaff and students.(NOTE: these are not a requirement for graduation or sitting for the initial certifications examinations.) They should **practice** teaching the nuances of basic medicine procedures to the junior members of their housestaff, and should know the limits of those tests. They should **practice** developing an understanding of tests outside their specialty, developing an understanding of the clinical applications of new radiologic, laboratory, and surgical technique. They should **master** the skills needed to research the data needed to come to a decision of clinical utility/risk/benefit regarding an intervention they had not previously seen (i.e., peripheral angioplasty, genetic screening tests, chest CT screening, etc.).

The PGY3 resident should develop a **mastery** of information resource utilization. He/she should be able to readily teach and lead other students in their quest to develop clinical questions, and should **practice** teaching others how to search successfully. The resident should be facile in the use of multiple information sources, and should **practice** critically appraising those sources for their strengths and weaknesses. The senior resident will be **introduced** to concepts of how to develop systematic reviews, and should be **introduced** to the concepts of using information systems to streamline current practices to increase their quality and/or efficiency.

Medical Knowledge - Intern

The intern must develop a basic working knowledge of the major FCIM curriculum topics, and be able to identify the major treatment modalities and their potential complications. The intern must also demonstrate the skills to use electronic, text, and online library resources to quickly identify and repair knowledge gaps as they are identified. Interns should have a **mastery** of the basic science and pathophysiology behind the major curricular topics, and should be **practicing** short working differentials (with discriminating features) for the major disorders.

Medical Knowledge - Resident

The PGY2 resident must **master** the basic contents of the FCIM curriculum to include **practicing** the application of a vast array of exam, laboratory, and radiological studies to help discriminate among different items in a differential. The PGY3 resident should **practice** developing discriminating skills that allow him/her to weigh findings based on their sensitivity and specificity, and should be introduced to concepts of educational theory and its role in diagnosing young learners and assisting in their application of more limited medical knowledge to clinical situations. The senior should **practice** these skills as both an observer of student performance at the bedside and in didactic format on rounds. The resident should **master** the use of electronic, text, and online library resources for information retrieval, and should practice teaching his/her team members to refine and improve their own searches.

Interpersonal and Communication Skills - Intern

The intern should **practice** skills that enable him/her to establish and maintain professional relationships with patients and families of patients. The intern should **master** skills that allow him/her to build team consensus, promote teamwork among his/her students, and work through disagreements with fellow staff in a constructive manner.

Interpersonal and Communication Skills - Resident

The PGY2 resident should **master** skills that enable him/her to establish and maintain professional relationships with patients and families of patients. The PGY3 resident should master skills in team leadership, including dealings with team members with discordant goals and objectives, and should constructively lead in a manner that effectively accomplishes patient care while supporting the learners around him/her.

Professionalism - Intern

The intern is expected to **practice** demonstrating behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and a responsible attitude toward patients, profession, and society. The intern should show this in protecting patient privacy, issues of informed consent, and confidentiality.

Professionalism - Resident

The PGY2 resident is expected to **master** demonstrating behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and a responsible attitude toward patients, profession, and society. The PGY3 resident should show this in protecting patient privacy, issues of informed consent, and confidentiality.

Practice-Based Learning and Improvement - Intern

The intern will be **introduced** to the concepts of quality and efficiency measures of care for groups of patients. The intern will be **introduced** to common barriers affecting groups of patients, and will attempt to develop processes to improve their care. The intern will receive exposure to a unique set of patients — a mix of well-insured private patients from the practice staff, Medicare patients, and the completely uninsured and underserved population.

The intern will **practice** searching the medical literature in order to understand best practice for groups of diseases encountered. The intern will **practice** self-evaluation and develop a willingness to learn from and use experience to improve his/her knowledge, skills, and attitudes as well as to improve processes of care for his/her patients.

The intern will help implement and define order sets for a physician order entry system, and will implement best practices used elsewhere as well as guidelines from the literature to improve quality.

Practice-Based Learning and Improvement - Resident

The PGY2 resident should **master** the techniques of practice-based quality assessment introduced to him/her during the internship year.

The PGY2 resident will **master** searching the medical literature in order to understand best practice for groups of diseases encountered. The PGY3 resident will **master** a life-long process of self-analysis for continuous improvement in knowledge, skills, and attitudes, as well as in developing processes of care for his/her patient population.

Systems-Based Practice - Intern

The intern will be **introduced** to the concept of team leadership, in which ancillary staff will be directed by the intern to best serve the needs of the patient. The intern will be **introduced** to practice and delivery systems as they interface with his/her care of patients. This includes support staff within the Hospital, such as case managers, social workers, etc., as well as community-based support systems, including home care and hospice. The intern will be **introduced** to the importance of advocacy for patients within the healthcare system.

Systems-Based Practice - Resident

The PGY2 resident will **practice** and the PGY3 resident will **master** building consensus among ancillary staff. He/she should assume the role of team leader, building consensus among consultants and family members, and bringing together divergent views of team members and family through group and individual discussion. He/she should feel comfortable incorporating the patient's belief system and desires into the final plan of care. He/she should be recognized by the family and consultants as the patient advocate. The PGY2 resident will **practice** and the PGY3 resident will **master** basic principles in areas of cost effective care, applying his/her knowledge of the larger system of health care through his/her development of inpatient and outpatient quality care initiatives (as described above in Practice-Based Learning). The PGY3 resident should **master** interactions with ancillary staff (PT, nutrition, social service), developing a working relationship and understanding of the benefits and limitations of these services.

Osteopathic Philosophy and Osteopathic Manipulative Medicine (OMM) – Intern

The intern will become competent with performance of osteopathic structural exam. He/she will be capable of palpating and naming somatic dysfunctions. The intern will know red flags and contraindications for osteopathic manipulation. The intern will become familiar with at least two OMM techniques (soft tissue/myofascial release, muscle energy techniques, high-velocity-low-amplitude techniques, articulatory technique, strain/counterstrain technique, and/or lymphatic pump techniques.

Osteopathic Philosophy and Osteopathic Manipulative Medicine (OMM) – Resident

In addition to the intern skills, the PGY2 resident will accurately palpate and name somatic dysfunctions, appropriately treat those somatic dysfunctions using at least 3-4 techniques, develop higher level skills in the

evaluation of neck, shoulder, low back, knee and ankle, effectively treat trigger points with manipulation or injection, develop basic knowledge of proper billing for OMM techniques. The PGY3 resident will develop more advanced palpatory skills, work up and appropriately refer patients with red flags for manipulation, treat somatic dysfunction using at least 4-6 techniques, become fully proficient in billing OMM techniques, demonstrate capacity to use OMM techniques independently in his/her continuity practice.

Duration and Scope of Education

The ABIM requires that there be 36 months of full-time medical residency education which shall include:

- At least 30 months of training in general internal medicine, subspecialties of internal medicine, critical care medicine, geriatric medicine, neurology, and emergency medicine. Up to four months of the 30 months may include training in non-internal medicine primary care areas (e.g., dermatology, office gynecology, or orthopedics).

- Up to three months of other electives approved by the Internal Medicine Program Director.

- Up to three months of leave for vacation time, parental leave, or illness. Vacation or other leave cannot be forfeited to reduce training time.

In addition, the following requirements for direct patient responsibility must be met:

- At least 24 months of the 36 months must occur in settings where the resident personally provides, or supervises junior residents who provide, direct care to patients in inpatient or ambulatory settings.

- At least six months of the direct patient responsibility on the internal medicine rotations must occur during the R1 year.

Other requirements for certification as defined by the ABIM include:

- Clinical Competence (six competencies) as defined by yearly clinical competence evaluations by the Program Director:
    - Satisfactory ratings in overall clinical competence and moral and ethical behavior in each year of training.
    - Residents must receive satisfactory ratings in each of the components of clinical competence during the final year of required training.

- Procedures Required
  Residents must meet standards of cognitive competence (indications, contraindications, sterile technique, specimen handling, interpretation of results and appropriately obtaining informed consent) for all of the following – abdominal paracentesis, ACLS, arterial line placement, arthrocentesis, central line placement, drawing venous blood, drawing arterial blood, incision and drainage of abscess, lumbar puncture, nasogastric intubation, Pap smear and endocervical culture, peripheral venous line placement, pulmonary artery catheter placement, and, thoracentesis. Capacity to perform safely and competently will be required for ACLS, drawing venous blood, drawing arterial blood, Pap smear and endocervical culture, and placing a peripheral venous line. Capacity to perform safely and competently is strongly encouraged for all internal medicine graduates in the following: lumbar puncture, arthrocentesis, and abdominal paracentesis. Competency in central line placement and thoracentesis is encouraged when this will be of value for the resident's future professional performance.

- Procedures Required – Osteopathic
  The resident must have training and experience in pelvic exams, central venous line placement, arterial puncture for arterial blood gases, osteopathic manipulative treatment and endotracheal intubation to include, at minimum: indications; contraindications; complications; limitations and evidence of competent performance.

  The resident must have training and experience in arthrocenteses, peripheral blood smears, exercise stress tests, ambulatory ECG monitors, lumbar puncture, spirometry, sputum gram stain, urine

microscopy, vaginal wet mounts and thoracenteses to include, at minimum: indications; contraindications; complications; limitations and interpretation.

- Please note that the listed requirements are subject to change per ABIM policies, and the resident should review the ABIM website for the most up-to-date version.

Details of the EVALUATION process are described on pp. 45-46.

Job Description

PGY1 Resident

The first-year resident is independently capable of performing a history and physical examination of patients assigned to him/her for care. This database is used to develop a plan of assessment and a plan for care. Initial orders are written for care by the intern. The intern will work in collaboration with an upper year resident on some clinical services and will always work with a faculty attending, who is ultimately responsible for the patient's care.

PGY2 Resident

Second-year residents transition into independently functioning Internal Medicine residents under the supervision of a faculty attending. Degree of responsibility provided to the residents is based upon demonstrated proficiencies. PGY2 residents direct cardiopulmonary resuscitation efforts independently once they have been assessed to have that skill. They make independent decisions concerning patient evaluations in the ED with concurrent or subsequent review by faculty or attending physicians. They perform procedures independently when they have completed all requirements and have received approval from the program director. PGY2 residents provide supervision and guidance to medical students and interns.

PGY3 Resident

PGY3 residents function relatively independently during their clinical rotations, night call, and clinics. They work under the supervision of a faculty attending at all times. PGY3 residents are expected to demonstrate a greater depth of skill in each of the competencies, as described under program goals and objectives.

ALL Residents

All residents receive a written evaluation of all six competencies on each rotation. Other tools for training and evaluation include portfolio, Mini-CEX assessments, 360 assessments, ambulatory practice improvement plans, and OSCE/videotape reviews. Residents meet with their mentor at least 3 times yearly for formative assessment and meet with the Program Director twice yearly for both formative and summative review. All Categorical IM residents take the annual in-training examination in September of each year. There is bi-annual summative evaluation by the full-time faculty of each resident in the training program. Standards for advancement are described below and due process issues are covered in the Reading Hospital Resident Manual. The Manuals are reviewed with the entering residents and are available at all times on the Hospital's website.

Criteria for Advancement

Competency – PGY1	By the completion of the PGY1 year the resident will (both in the inpatient and outpatient setting):
Patient Care and Procedures	Be able to elicit a medical history that defines the presentation of illness, thereby assisting with making a diagnosis and developing a management plan.
	Be able to completely perform an appropriate exam on patients presenting with common medical problems.
	Demonstrate knowledge of preventive care guidelines.
	Be able to integrate past and current clinical information in order to develop a problem appropriate diagnosis.
	Be able to initiate a correct treatment plan based on assessment of common medical problems.
	Be able to prioritize problems in order to complete daily patient care duties in an accurate and timely manner.
	Demonstrate appropriate monitoring and follow-up of patients, including laboratory data and test results.
	Demonstrate caring and respectful behaviors with patients and families.
	Work effectively as a member of the health care team.
	Be able to perform the ABIM-required internal medicine procedures with supervision.
Medical Knowledge	Demonstrate a satisfactory level of basic and clinical science knowledge in order to recognize and treat common diseases.
	Identify and use various educational resources to seek information about patients' diseases.
	Apply learned medical knowledge to diagnosis, treatment and prevention of disease.
	Attend conferences to continuously learn and reinforce medical knowledge and skills.
	Be an active participant in daily rounds and outpatient sessions.
Practice-Based Learning	Be able to formulate clinical questions in the day-to day care of patients.
	Access medical information using various educational resources to assist in medical decision-making.
	Be able to identify his/her limitations of knowledge and skills and seek help when needed.
	Accept feedback and develop self-improvement plans when appropriate.
	Start to develop skills in teaching with patients, staff and colleagues.
	Show ability to analyze written work, teaching style, patient care issue and self- evaluate current competence.
Interpersonal & Communication Skills	Demonstrate complete, legible, and timely documentation of medical information.
	Use effective listening, narrative and non-verbal skills to elicit and provide information.
	Be able to accurately and concisely present to attendings and colleagues.
	Be able to dictate an accurate and concise history and physical and discharge summary.
	Be able to perform and accurate and concise signout to other team members.
	Be able to communicate in oral and written form a cohesive plan in signout rounds.
Professionalism	Demonstrate professional conduct in interactions patients and their families, colleagues, and other members of the health care team.
	Demonstrate respect, compassion, integrity, and honesty.
	Show responsibility for meeting program requirements.
Systems Based Practice	Show responsibility for meeting requirements of medical practice the Reading Hospital/Berks County setting: timely dictations and notes, timely evaluations of attendings/peers/etc.
	Advocate for high quality patient care and assists patients in dealing with system complexity.
	Be able to recognize system problems.
OMM	Demonstrate competency in performance of structural exam.
	Demonstrate proficiency in anatomical identification of somatic dysfunction.

	Sign yearly Osteopathic Pledge of Commitment document.
	Sign yearly AOA Code of Ethics document.
	Know relative and absolute contraindications for osteopathic manipulation.
	Demonstrate proficiency of a minimum of 2 OMM techniques (soft tissue/myofasical release, muscle energy techniques, high-veloity-low-amplitude techniques, articulatory technique, strain/counterstrain technique, lymphatic pump techniques).
	Demonstrate understanding of the somato-visceral relationships and the role of musculoskeletal system in disease.
Competency – PGY2	**By the completion of the PGY2 year, the resident will (both in the inpatient and outpatient setting)**
	continue to demonstrate competency in the Promotion Criteria for PGY1 to PGY2 in Patient Care and:
Patient Care and Procedures	Be able to obtain a precise, logical and efficient history.
	Be able to elicit subtle findings on physical examination.
	Be able to use diagnostic procedures and therapies appropriately.
	Be able to interpret results of diagnostic tests and procedures properly.
	Be able to analyze clinical data to make informed decisions about the management of the patient's health and illness.
	Be able to understand and weigh alternatives for diagnosis and treatment.
	Demonstrate consideration of patient preferences when making medical decisions.
	Be able to manage multiple medical problems at once.
	Demonstrate an effective working relationship with other members of the health care team including nurses and ancillary staff.
	Be able to recognize and choose an appropriate care location for inpatient conditions.
	Be able to modify diagnostic and therapeutic plans while supervising PGY1 residents and medical students.
	Be able to perform most ABIM-required internal medicine procedures without supervision.
	Show leadership when needed in leading a QI multidisciplinary group.
	Be able to manage difficult patients and be facile in initiating behavioral change.
Medical Knowledge	**Continue to demonstrate competency in the Promotion Criteria for PGY1 to PGY2 in Medical Knowledge and:**
	Demonstrate advancement in basic and clinical science knowledge in order to recognize and treat common and uncommon diseases.
	Demonstrate knowledge of epidemiologic and social-behavioral sciences and apply that knowledge to the care of the patient.
	Demonstrate awareness of indications, contraindications and risks of commonly used medications and procedures.
	Demonstrate leadership and teaching skills in managing daily rounds and outpatient sessions.
	Attend and participate in conferences (Core conferences and Morning Report) to continuously learn and reinforce medical knowledge and skills.
Practice-based Learning	**Continue to demonstrate competency in the Promotion Criteria for PGY1 to PGY2 in PBL & Improvement and:**
	Be able to formulate, search, and answer clinical questions using the scientific literature.
	Demonstrate continual self-evaluation with insight and initiative to correct deficiencies and develop new skills.
	Demonstrate teaching initiative and skills with patients, students, and colleagues.
	Demonstrate the ability to recognize personal deficiencies and develop remediation plans.
Interpersonal & Communication Skills	**Continue to demonstrate competency in the Promotion Criteria for PGY1 to PGY2 in Interpersonal and Communication Skills and:**
	Demonstrate the ability to facilitate patient care through effective communication with other members of the health care team.
	Be able to create and sustains therapeutic and ethically sound relationships with patients and families.
	Demonstrate that he/she provides effective education and counseling to patients and families regarding health and illness.
	Demonstrate the ability to effectively discuss informed consent, resuscitation status, and death and dying with patients and families.
Professionalism	**Continue to demonstrate competency in the Promotion criteria for PGY1 to PGY2 in Professionalism and:**
	Display initiative and leadership in his/her daily role as a resident physician.

	Be able to provide safe and effective patient care through effective communication when transitions of care are necessary.
	Demonstrate commitment to ethical principles including but not limited to patient confidentially, informed consent, and business practices.
	Demonstrate sensitivity to patient culture, gender, age, preferences and disabilities.
	Demonstrate progress in meeting some or most program requirements including the completion of scholarly projects.
	Display initiative in career planning after the completion of residency.
Systems-Based Practice	**Continue to demonstrate competency in the Promotion Criteria for PGY1 to PGY2 in Systems-Based Practice and**:
	Demonstrate effective and timely participation in the system-approach to outpatient follow-up in order to improve the quality of patient care delivery.
	Demonstrate partnership with colleagues and other health care providers to assess, coordinate, and improve patient care.
	Participate in developing ways to improve systems of practice and health management.
OMM	**Continue to demonstrate competency in the Promotion Criteria for PGY 1 to PGY2 in OMM and:**
	Demonstrate proficiency in treatment of identified somatic dysfunction using at least 3-4 techniques
	Develop higher level skills in evaluation of neck, shoulder, low back, knee and ankle
	Effectively treat trigger points with manipulation or injection
	Demonstrate basic knowledge of proper billing for OMM techniques
Competency – PGY3	**By the completion of the PGY3 year, the resident will (both in the impatient and outpatient setting)**
	continue to demonstrate competency in the Promotion Criteria for PGY2 to PGY3 in Patient Care and:
Patient Care and Procedures	Be competent in the care for patients with the majority of internal medicine problems.
	Be able to effectively lead a ward team, that together is able to demonstrate appropriate patient care delivery.
	Demonstrate the ability to devote an appropriate amount of time to diagnostic reasoning and treatment as related to the complexity of the problem(s).
	Be able to reason well in ambiguous situations.
	Be able to perform all ABIM-required internal Medicine procedures without supervision.
	Demonstrate effective teaching skills in small group settings.
Medical Knowledge	**Continue to demonstrate competency in the Promotion Criteria for PGY2 to PGY3 in Medical Knowledge and:**
	Demonstrate continued advancement in medical knowledge as appropriate for ABIM certification.
	Demonstrates an investigatory and analytic approach to clinical situations.
Practice-Based Learning & Improvement	**Continue to demonstrate competency in the Promotion Criteria for PGY2 to PGY3 in PBL & Improvement and:**
	Be able to locate, appraise, and assimilate scientific literature into daily practice.
	Be able to analyze personal practice patterns systematically, and looks to continuously improve.
	Demonstrate use of teaching skills to create an effective learning environment for students, junior housestaff, and patients.
	Demonstrate the ability to form, collect and answer patient-based clinical questions on a routine basis.
	Can routinely analyze, critically appraise and develop plans for improvement after reflective analysis of skills.
Interpersonal & Communication Skills	**Continue to demonstrate competency in the Promotion Criteria for PGY2 to PGY3 in IP & C skills and:**
	Be able to demonstrate the development of long term professional relationships with patients followed since early in the R1 year.
	Be able to demonstrate high level dialogue with colleagues that facilitate collaborative patient care.
Professionalism	**Continue to demonstrate competency in the Promotion Criteria for PGY2 to PGY3 in Professionalism and:**
	Be able to act appropriately in the role as a medical consultant

	Demonstrate the ability to communicate with consultants effectively in oral and written form; can properly document consultative work.
	Demonstrate progress in meeting all program requirements including the completion of scholarly projects.
	Demonstrate ability and desire to use knowledge of the health care system to effectively advocate for patients.
Systems-based Practice	**Continue to demonstrate competency in the Promotion Criteria for PGY2 to PGY3 in Systems-Based Practice and:**
	Demonstrates the ability to adapt to change.
	Demonstrate familiarity of utilization of resources that assist with patient care and disposition.
	Demonstrate knowledge of types of medical practice and delivery systems.
	Be able to practice effective allocation of health care resources that does not compromise the quality of care.
OMM	**Continue to demonstrate competency in the Promotion Criteria for PGY2 to PGY3 in OMM and:**
	Develop advance palpation skills in order to function as an independent practitioner.
	Demonstrate ability to provide appropriate treatment and care when manipulation is contraindicated.
	Know how to treat somatic dysfunction using at least 4-6 techniques.
	Become fully proficient in OMM billing techniques.
	Demonstrate capacity to use OMM techniques independently in his/her continuity practice.

Sick Day Policy

It is the policy of Tower Health's residency programs to support positive health behaviors for its trainees. Residents are expected to obtain a primary care provider, and follow a positive lifestyle program that promotes healthy behavior. Twelve days per year are set aside as allowable sick days before the resident would be required to utilize vacation time. In the event that the resident's illness or injury precludes work for two or more consecutive days, a physician's note will be requested by the Program Director. In addition, at the discretion of the Program Director, a physician's note may be requested in the setting of repeated absences averaging one or more per month. It is required that each resident not reporting for duty at their regularly scheduled time due to injury or illness notify the main office of the Department of Medicine, the Junior Faculty Member, TRH-IMP/BH (if applicable) and their assigned attending physician of the absence. On weekends, a resident must notify the faculty member on call as well as the senior resident on call. This applies to all residents on rotations. Please note that sick days are counted by the accrediting bodies as time away from the residency, and therefore will need to accounted for when determining whether extension of residency is needed.

Absence from Program

Vacations and Holidays:. Residents should contact the Junior Faculty/Chief Resident to determine vacation eligibility, as well as to receive approval for proposed vacation schedule.

With prior written approval of the Program Director and the Human Resources Department, residents may choose to substitute a religious holiday of choice in lieu of one of the traditional six holidays. Residents should make this request through their Program Director and Chief Residents at the START of the year.

- Interns are granted 2 weeks of vacation plus one week at Christmas/New Year.
- Upper years are granted 3 weeks of vacation plus one week at Christmas/New Year.

Unless there are major exceptions (approved by the Program Director), the following rules should apply for vacations and conferences:

- Vacations should be taken in blocks of 1, 2 or 3 weeks.
- Vacations should be taken only during open times in the schedule.
- Vacations may not be taken during HTS/ICU/ /Hospitalist/A4 rotations and should not be taken during Cardiology, IMP/BH rotations, unless approved by the Junior Faculty Member and Program Director.
- Vacations chosen during other times should be planned in conjunction with a rotation that allows 2- or 3-week blocks.
- Changes to vacations may be made only with approval of the attending in charge of each affected rotation as well as the Junior Faculty Member and must occur a minimum of 6 weeks before the start of the earliest affected rotation.

- If the resident is within 6 weeks before the start date and clinic patients are already scheduled, the resident will have to call those patients themselves to facilitate re-scheduling.
  - Vacation requests for the year must be submitted to the Junior Faculty Member no later than the end of Block 2 so that any conflicts can be addressed and preceptors can schedule accordingly. Those not submitting requests will be assigned vacation time.
  - Per hospital HR policy, there is no payout for unused vacation, and full use of vacation time is strongly encouraged.

Conference Time

PGY2 and PGY3 residents may attend one conference for the purposes of advancing their education and career goals. The resident is not required to present at this conference. This conference will be paid from the educational fund. Five conference days will be granted for this purpose.

PGY2 and PGY3 are permitted to attend additional conferences as the first author on a poster or as a presenter. If the first author is not able to attend the conference, the second author may present in his/her place. Only one resident will be permitted to attend per accepted poster. Five conference days will be granted for these purposes. This conference can be paid from Dept of Medicine funds or educational funds.

One conference attended as first author or presenter will be paid from the Department of Medicine fund per year. Any additional conference will be paid from the educational fund or funded by the resident. Board review

courses (with the exception of the required ACOI board review/conference for DO residents) must be paid for by the educational fund or funded by the resident.

A maximum of 10 conference days combined will be granted per academic year. This includes conference attendances as first author or presenter (5) as well as attendance at an educational conference/board review (5). Five days are granted to DO residents attending the required ACOI conference and are not included in these 10 conference days.

PGY1 residents are permitted conference leave only as first author and at the discretion of the program director.

Conference leave will not be granted on HTS, ICU, NF or any A4 rotations. Conference attendance on continuity clinic blocks for non-primary care residents (IMP and BH rotations) will be decided based on staffing needs of their respective clinic as reviewed by Associate Program Director, Ambulatory Medicine and subject to final approval by the Program Director. Residents should appropriately plan ahead when the block schedule is made to ensure they will not be on these required rotations at the time of desired conferences. Conference leave is granted only if the staffing needs of the residency are met.

No rental cars will be paid for by the residency without documented proof of necessity; taxi/shuttle transportation to and from the airport at the conference site will be covered. If a resident owns a car and plans to drive to the conference, a rental car will not be approved. The resident is expected to attend the conference and be able to provide proof of such after the event. Approval of funds for flight, hotel and other travel expenses is subject to approval by the department of medicine. Inordinate expenses may not be reimbursed if deemed to be unnecessary by the program director.

ACOI conference for DO residents
Osteopathic residents are required to attend one ACOI conference during their 3 year residency, preferably in PGY2 or PGY3 year.
Osteopathic residents will be permitted to attend any ACOI conference or board review that satisfies the ACOI requirement. This is exclusive of the 5 conference days granted for an educational conference. If an Osteopathic residents choses to go to an additional ACOI conference/board review they are subject to the same stipulations named above for attending an educational conference.

Interview Time
Interview days off should be approved by the Junior Faculty member and Program Director and should also follow the usual Department of Medicine process for time away. If interview days exceed 4/year, time will be taken from PTO or the “winter break” days.

Duration of **conference time** should be determined in conjunction with the mentor and program director. If the resident is allowed to attend a second conference in a year, in order to present findings at the meeting, the duration of time away should be minimized. Funding for the second conference will come from the resident’s educational fund or out-of-pocket. Five days total will be allowed for conference from the resident’s educational fund.

In order to meet the RRC internal medicine regulations, the resident may need to make up for time lost due to away experiences, including total number of continuity medicine experiences and total percent ambulatory time. Emergency needs for absence should be made known to, and approved by, the Program Director. Any time taken off from the program without prior approval of the Program Director or designee (with the exception of illness) will be considered unexcused absences (for which you are not paid), and potentially must be made up.

More than 30 days of absence in an academic year for all reasons (health, vacation, interviews, emergencies) will require extension of the training year to obtain Pennsylvania licensure and ABIM credit for that academic year. The American Board of Internal Medicine states: “Up to one month per academic year is permitted for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities. Training must be extended to make up any absences exceeding one month per year of training. Vacation leave is essential and should not be forfeited or postponed in any year of training and cannot be used to reduce the total required training period. ABIM recognizes that leave policies vary from institution to institution and expects the program director to apply his/her local requirements within these guidelines to ensure trainees have completed the requisite period of training.”

The ABIM has taken the position that it is not educationally sound that such duties (maternity and child care) should substitute for training experiences, nor is it educationally justifiable that residents who do not use parental leave be required to train longer than those that do. If a resident finishes by the end of August, he/she will be eligible to sit for the Certifying exam. If the end date is in September or later, the candidate will have to wait to take the exam until the following year. The start of fellowship will be delayed an equivalent length of time, although this generally has not been a barrier in the past for residents finishing a few months out of cycle. The Pennsylvania State Board of Medicine requires a minimum of 11 months of training at each level of training to meet the graduate education requirements for unrestricted licensure.

The AOA states the following policy on Leave of Absence and Vacation:

a. The AOA Division of Postdoctoral Training/Trainee Services must be notified in writing of the training extension, with copies to the OPTI and specialty college. A copy must be maintained in the trainee's file.

b. All AOA-approved programs must offer a minimum of 10 business days (Monday through Friday) per contract year of vacation time and provide a maximum of 20 business days (Monday through Friday) per contract year of vacation, professional, sick or other leave as granted by the DME, unless such leave is designated by federal, state, training institution or union regulations. Required educational programs, OPTI programs or specialty college programs will not be counted against those days.
   - In such cases, federal, state, institution and/or union regulations shall supersede these policies for each contract year of training.

c. No more than 20 business days per contract year of leave may be granted for any purpose without extending the program.

d. If trainee is given a leave of absence for reasons of maternity, physical or mental disabilities and returns to duty, he/she may continue the training to completion.

The DME/program director has the authority to extend the trainee contract for a period of up to 3 months for leave, illness or remediation purposes without requesting approval for overlap of trainee numbers from the specialty college and/or PTRC. Any overlap in excess of 3 months shall require advance approval and be reported to the AOA Division of Postdoctoral Training, specialty college(s) and OPTI. A copy must be maintained in the trainee's file.

The training institution shall assist the trainee in obtaining confidential counseling, medical and psychological support services when indicated, including physician impairment assistance.

Questions should be addressed to the Director of the Internal Medicine Residency Training Program.

Sanctions Policy When the Resident does not Follow Process for Absence from the Program
Effective: 4/11/16

Respect for your patients and your colleagues are a cornerstone of being a physician. Processes are in place to define appropriate situations where resident absence from scheduled duties is appropriate and to allow the program to adjust for such absence. When a resident is absent and does not observe the formal notification process, he/she may impair patient care and also put undue burden on their resident colleagues. Observing this process is viewed as an important measure of professionalism. Lapses will be dealt with at the discretion of the Program Director and the Clinical Competency Committee.

Institutional Support

Sponsoring Institution

Tower Health serves as the sponsoring institution. Tower Health assures that an environment is created which allows for excellence in medical training. Details of its commitment to residency education are outlined in the RH Resident Manual, which is updated yearly.

Away Rotations

Upon approval of the Program Director, a resident may arrange a rotation at another institution if it offers an experience not available in Tower Health. An agreement shall be created as described in Section IV of the RH Resident Manual, which will include: the name of the supervisor at the host site; the inclusive dates of assignment; responsibilities of the supervisor to assure teaching, supervision and evaluation; financial arrangements and benefits; policies and procedures to be followed by the resident; and goals and objectives for the rotation. In doing so, the sponsoring institution and Program Director will assure appropriate quality of the away elective rotation. At least 6 months prior to the date of the away rotation, the Away Rotation Request should be initiated with the program coordinator. Given the time, expense and effort needed to arrange these rotations, it may take 6 months to reach an agreement with the away institution. The resident should demonstrate a reasonable commitment to the location when the request is made. A maximum of two away rotations will be permitted over a three-year period. Exceptions allowing for a third away rotation may be made in the case of the required Jefferson cardiology/pulmonary-critical care/hematology-oncology rotations for candidates for the Reading-Jefferson track fellowship positions (if required by said fellowship).

For residents who are considering fellowship training, the program will routinely allow 1 away rotation in the 2nd year of training. No away rotations will routinely be permitted in the 1st year of training for this purpose. Under certain circumstances, a 2nd away rotation in the PGY2 year might be considered, if there is an important educational/career goal. Given the extra burden this places upon the program, such residents may be assigned to the "jeopardy" resident position more commonly and could be called upon to support the program by contributing an extra service month in the PGY3 year. The resident must self-report to Risk Management as soon as possible any potential risk issues that may have occurred on an away rotation.

The policy will be reviewed on a year-by-year basis. The policy may be cancelled if there is evidence for an adverse impact upon the residency experience at Reading Hospital.

Facilities and Resources

Information Systems

Medical Library – The main Hospital library is located on B-3. The resident has access 24/7 by using his/her ID badge. The library houses extensive journal, text, and educational CD resources, along with full computer access. Journal articles not available in the library may be requested at no charge. Copying and scanning equipment is available. The Library's text listings are available on the Hospital's intranet. On line full text is available for a number of journals through the hospital's intranet site. An e-form is also present to request other articles.

Computer Access – The resident has access to all patient clinical information under an assigned user name and password, which should not be shared with others. Access may be through the Hospital's computer system. From-home access to patient information can also be requested. The computer system allows access to medical knowledge databases including UpToDate, Micromedex, Medline (EBSCO), and the Internet.

Radiology and Non-Invasive Cardiology Reports are available as soon as they are dictated and before they are transcribed through a telephone system. The resident may call 4296, and enter the appropriate access code and medical record number to receive these reports.

Medical Records – All inpatient history, physicals, and discharge summaries will be dictated/typed into EPIC and become a part of the patient's lifetime clinical record. Similarly, consultations should also be dictated/typed. The resident will use electronic signature to sign these reports. The residents will utilize EPIC to maintain their patient ambulatory records.

Facilities

Sleep Quarters – On-call sleep quarters are located on A3. Each resident has a key to their PGY-level call room. This key is not to be copied, and must be returned upon termination of employment. Separate rooms are assigned for each intern and upper-year resident. Bathroom and shower facilities, computer, refrigerator with water and soda, as well as light snacks are available on site.

A key for the Jeopardy call room may be obtained through the Department of Medicine but must be returned the next day. After hours, Security should be contacted to obtain a key to the Jeopardy call room.

There is a designated ICU call room for residents on that rotation.

In addition, there are two rooms in M-Building, M106/M107, which serve as Flex Rooms available to all hospital staff on a first-come first-serve basis. The rooms are reserved for one-night stays. The keys are issued from the Security Desk in the 5th Avenue Lobby. Keys are to be returned the next morning.

Resident Lounge R3 – The resident lounge on R3 can be accessed through code 2468#. This code should not be shared with others. A television, lounge chairs, food, and beverages are available. Food and beverages include water, soda, milk, juice, bread, crackers, cereal, peanut butter, fruit, potato chips, and pretzels. This room and an adjoining study houses three computers with M*Modal microphones and printer.

Internal Medicine Residency Lounge A3911 – Resident mailboxes are located at this site. Important announcements for residents are commonly posted here.

K-Building Second Floor (K2) area – Entry code is 714*. Please do not share this with others. K2 has an exercise facility for residents including a treadmill, stepper, and weight equipment. A television is located in the exercise room. K2 also has two bedrooms, rooms K2-801 and K2-802, assigned to the internal medicine residency. These may be used by medical residents on a first-come-first-serve basis in the event the resident cannot readily travel home when not on call. Keys are available in the Department of Medicine office.

K-Building 4th Floor (K4) area – Houses dormitory-style sleep quarters for students and some one-year residents. Note that the pool table in the common area may be used by any resident. Key is available in the Department of Medicine office.

A4 Clinic – Site of many of the Medical Subspecialty clinics *(see Ambulatory Education).*

Department of Medicine Office – Staff of the Department of Medicine Office on B2 may be reached by dialing ext. 8133 or ext. 8255. The department secretaries support the residency educational program by facilitating communication between residents and core faculty, collecting attendance forms, supporting data collection on the My Evaluations database, supporting the interview process for resident applicants, supporting the student education programs, and helping residents with general "system" issues.

The Residency Program is also staffed by a Program Coordinator; in conjunction with the Director, the Program Coordinator is responsible for overall management of the residency program. In addition, the Program Coordinator assures compliance with the RRC and Institutional Requirements to maintain accreditation.

Patient Population

Reading Hospital serves as the major community and referral hospital for a population of more than 400,000 in

Berks County and adjacent regions. The demographic spectrum extends from inner city to rural, and represents a broad ethnic spectrum. The residents' inpatient service includes patients directly admitted from RH IMP, and all other patients are taken in rotation with the hospitalist group. The resident's outpatient clinic group includes adult patients age 18 and older. RH IMP population is a combination of Spanish-only speaking members of Reading's city population, and a practice comprised of individuals reflective of the area's suburban ethnic mix.

Pathology Material

A review is performed by the attending physician, Program Director, or Mentor for all patient deaths in which a medical resident was involved in that patient's medical care. This information will be utilized when appropriate for group educational review and to provide feedback to the resident involved in the care of the deceased.

A request for autopsy is strongly encouraged for all patients who die on the resident services. When an autopsy is approved on a resident service patient, the resident should complete the autopsy form, and provide contact pager number and Program Director contact information. The resident will be notified by Pathology of the time of autopsy. All categorical residents are expected to attend as many autopsies on their patients as possible, but at least one should be attended prior to completion of training. The pathologist's report of findings will be forwarded to the Department of Medicine office, and will be maintained by the Program Coordinator. Residents will be contacted by e-mail on the availability of these reports.

Support Services

Hospital Support Services are described in Part II of the Reading Hospital Resident Manual.

Departments are also described in individual sections of the Reading Hospital Resident Manual. Additional information may be available on the Hospital website at www.towerheatlh.org.

Resident Appointment

Eligibility

Criteria for Intern Selection

LCME or AOA-approved Medical School graduates or candidates for graduation who are eligible for a Graduate Training License in the state of Pennsylvania are candidates for selection. Enhancing criteria for selection include: election to honorary academic organizations (Phi Beta Kappa, AOA); positive evaluations for experiences in Internal Medicine during medical school; high scores on USMLE Steps 1 and 2 (or the corresponding osteopathic examinations); strong letters of endorsement from Deans/Department Chairs; and documentation of academic success (class standing, research publications, student awards). In addition, International Medical Graduates must have ECFMG certification, and preferably, experience in the US healthcare system.

All candidates must complete a successful multiple mini-interview with the faculty and trained resident interviewers. Final rankings for selection are submitted to the NRMP or NMS after review by a faculty-resident group based on the consideration of the above criteria. *(The Department also follows the Institutional Policy on Resident Selection described in the Resident Manual.)*

Criteria for Designated Osteopathic Resident Selection

The program embraces osteopathic medical education as a valuable component of the formation of osteopathic Internists. The program expects designated osteopathic residents to incorporate osteopathic principles of practice (OPP), including OMM as appropriate, into their patient care and reaffirms that OPP has application to a career in Internal Medicine and its subspecialties. Therefore, all graduates of a COCA-accredited College of Osteopathic Medicine who hold a DO degree and enroll in the program will be designated osteopathic residents. Applicants who are graduates of LCME-accredited medical school or those who are graduates of a medical school outside of the United States or Canada and who seek to be designated osteopathic residents must meet the following additional requirements:

- Residents must have sufficient background and instruction in osteopathic philosophy and techniques in manipulative medicine sufficient to prepare them to engage in the curriculum of the program.
- Residents must have instruction to include: osteopathic philosophy, history, terminology, and code of ethics; anatomy and physiology related to osteopathic medicine; indications, contraindications, and safety issues associated with the use of osteopathic manipulative treatment; and palpatory diagnosis, osteopathic structural examination and osteopathic manipulative treatment.
- Residents must have completed a course in Osteopathic Principles and Practices (OPP) which instructs these requirements at a college of osteopathic medicine prior to matriculation in the program.

Resident Transfers

Any resident who wishes to transfer from another program must provide records to support that he/she meets acceptance criteria, as well as a letter from his/her current Program Director. This letter must summarize the competencies already accomplished.

USMLE 3 Examination
All residents must pass USMLE 3 examination before they can advance to the PGY 3 year. This is a requirement for Pennsylvania State Licensure. We strongly encourage residents to take the examination by the completion of the PGY1 year.

Number of Residents

The Internal Medicine Residency at Reading Hospital is approved for 36 residents by the Internal Medicine Residency Review Committee of the ACGME. It is the desire and expectation of the staff that all first-year categorical residents will complete their three years of training at Reading Hospital.

Faculty

Program Director

Dr. Benjamin Lloyd serves as the Program Director. Dr. Ryan Zimmerman serves as the Osteopathic Program Director. The Program Director monitors licensure requirements. The Program Director supervises resident orientation, develops the program of study with each resident, and finalizes all recommendations for modifications of the curricular program. The Program Director reviews all forms of resident feedback. Along with the resident's mentor, the Program Director will define the resident's progress and determine appropriateness of advancement. The Program Director organizes the in-training examination program, and will orchestrate the development of programs of remediation in concert with the Clinical Competency Committee. The Program Director monitors resident stress, fatigue, and general well-being. The Program Director oversees curriculum and assures that the curriculum is consistent with requirements established by the ACGME for internal medicine training programs. The Program Director maintains a process of continuous improvement for the individual resident, the program, and the patients cared for by resident services. The Program Director meets with each resident biannually, and creates a summary statement of the resident's progress. The Program Director will routinely notify each resident by February 15 of the intent to advance the resident on June 24. The Program Director will create a summary document of all graduating residents.

Faculty

Educational faculty support the Program Director in assuring the creation and implementation of an individualized program of learning that will support each resident's goal of mastery of the Six Competencies as defined by the national accrediting bodies.

Each resident will be assigned a mentor, who will provide individualized attention to the personal and professional development of that resident. The Mentor will formally meet with the resident at least three times yearly to review resident progress. The formal Mentor review format is described in Appendix A.

A full-time faculty member will be on call at all times, and is available to discuss any patient care issues. The call schedule is posted in the resident library, and can also be obtained from the Hospital operator. A faculty member will also serve as the resident's ambulatory clinic supervisor.

The ambulatory component of the training program will be supervised by the following attendings: Drs. Suzanne Wenderoth, Neha Majmudar, Ronald Herb, Jon Nesfeder, Debra Zimmerman, and Bryan Romero. Dr. Lisa Motz coordinates with Dr. Neha Majmudar to handle student issues as the Site Clerkship Director.

Dr. Anthony Donato, Inpatient Associate Program Director, coordinates the clinical research program. Other academic hospitalists include Dr. Eugene York, who also directs the Transitional Year Program, Dr Lisa Motz, who is student clerkship director as above, and Dr. Jeremy Ellis and Dr. Sarah Luber. Dr. Cecilia Smith, Chair of Medicine, supports the interface between the Department and Residency needs. She also supervises M&M conference. Dr. Jeremy Ellis coordinates departmental QI. Dr. Sarah Luber leads a departmental and hospital wellness program.

The Junior Faculty Members (Richard Loynd, DO and Kaitlin Tarconish, DO) in AY 2018-19) serves as the resident's advocate, and provides back-up support when needed by any resident. The Junior Faculty Member provides the resident's perspective at weekly and monthly faculty meetings, supervises topics for Chief's Rounds, organizes topics for Journal Club, provides support to faculty providing formal didactics to residents, and serves as a teaching attending on inpatient services, as well as runs simulations for the MATT curriculum.

Residency Program Coordinator

The residency program employs a full-time Program Coordinator. Mary Lisney (x8640) is responsible for assisting the Program Director with administering policies that govern the function of medical education. The

Program Coordinator is responsible for implementing and overseeing strategies to track resident performance and in ensuring compliance to all regulatory requirements.

The Educational Program

Curriculum

General Information

First year Categorical Internal Medicine (subject to change)	Second year Categorical Internal Medicine (subject to change)	Third year Categorical Internal Medicine (subject to change)
4 blocks Inpatient Medicine 1 block ICU 1 block Cardiology 2 blocks Ambulatory Care 1 block Night Float 1 block IMP 3 block elective (at least 1 electives ambulatory based)	2 blocks Inpatient Medicine (hospitalist/HTS) 1 block ICU 1 block Nephrology 1 block Cardiology 1 block ER 2 blocks Ambulatory Care 1 block Night Float 1 block IMP 1 block Transition of Care 3 blocks electives (at least 1 elective ambulatory based)	2 blocks Inpatient Medicine (HTS/Hospitalist) 1 block ICU 1 block Cardiology 1 block Neurology 1 block Ambulatory Care 1 block Night Float 1 block Geriatrics 5 blocks elective (at least 2 elective ambulatory based)

Choice of rotations:
Each resident is responsible to review the requirements for ACGME/TY/ABIM/AOA training and work with the mentor to assure that all requirements are met.

Of particular note:
Categorical Residents (MD and DO):

- Categorical medicine residents must have **1/3** of their training in the **ambulatory setting**
- Only 3 months of the 36 months can be spent in **non-clinical endeavors**
- Continuity experience for categorical must include at least **130 half day continuity outpatient** sessions over 3 years.
- **ER training** (4 weeks) is required during the 2nd or 3rd year of residency (those who had PGY1 ER rotation are not required to do another rotation.)
- **Renal** and **Neurology** are required once during the categorical medicine residency
- **Geriatrics** (4 weeks) is required
- **TRH IMP** block required for PGY 2 and non-osteopathic PGY1
- **Women's Health** required for osteopathic PGY1

In recognition of the fact that office schedules, preceptor assignments, and ensuring evaluation opportunities take a significant amount of time and energy from the staff in the department of medicine and the staff at the elective site, all residents must choose their in-house elective rotations at least 6 weeks before the start date of the rotation. Additionally, all rotations that have already been chosen cannot be changed with less than 6 weeks' notice to the Department of Medicine. A manual of elective opportunities is available from Mary Lisney to assist residents in their elective choices. If a resident does not choose an elective within 6 weeks of the start date of the block of that elective, an elective will be assigned to the resident by the Junior Faculty Member and Program Director consistent with the resident's indicated career interest.

Primary Care Track Allopathic Schedule

*Block Curriculum (subject to change)**:***

PGY1

Rotation	Duration (blocks)
General Internal Medicine Inpatient	3
ICU	1
Night Float	1
Cardiology	1
Ambulatory – Berkshire Heights	2
Ambulatory – A4 Subspecialty Clinics in AM and Ambulatory Subspecialties in PM	1
Women's Health	1
Elective	3

PGY2

Rotation	Duration (blocks)
General Internal Medicine Inpatient	2
ICU	1
Night Float	1
Cardiology	1
Ambulatory – Berkshire Heights	2
Ambulatory – A4 Subspecialty Clinics in AM and Ambulatory Subspecialties in PM	1
Psychiatry	1/2
Neurology	1
Geriatrics	1/2
Elective	3

PGY3

Rotation	Duration (blocks)
General Internal Medicine Inpatient	2
ICU	1
Night Float	1
Ambulatory – Berkshire Heights	3
Geriatrics	1/2
Emergency Care Unit	1
Elective	2 1/2
Musculoskeletal Medicine	1
Dermatology	1

Longitudinal Curriculum: Concurrent with block curriculum over 3 years of training

- Continuity Ambulatory Experience at Community-based Practice Site (1/2 day/week once or twice weekly based upon rotation; none during ICU, Night Float or General Inpatient Medicine rotation)
- QI team project – longitudinal.
- Portfolio project – longitudinal.

Ambulatory – Berkshire Heights – The resident will train at the community-based practice site for both block and longitudinal experience over their 3 years. The ambulatory curriculum has been expanded to promote a greater depth of knowledge and skill for the spectrum of ambulatory medical problems, with greater focus on the care of patients with chronic medical illness, greater awareness of community resources, greater focus on office team functions, and greater depth of experience in process improvement. "Business issues in health care" are actively incorporated into the training curriculum.

During block rotations, the resident will provide care to his/her panel of patients approximately 8 half day sessions per week and will be involved in process improvement education and implementation 2 half days

weekly. Community outreach experiences may also occur during this time. The resident practice occurs in an office setting along with other primary care providers. Several core clinicians trained in faculty development and process improvement will serve as mentors. The resident will be an active participant in a practice that is developing a medical home model. The resident will develop skills in working in a team with other staff, including physician extenders. The resident will also become aware of organizational changes, resulting from the health system's evolution towards a clinically integrated organization.

Quality Improvement Project – A robust QI training curriculum already exists and is in its 10th year for the internal medicine residency. The primary track residents will continue in this 3-year long longitudinal "learn by doing" program, but will serve in separate teams that will focus on projects relevant to the ambulatory practice sites or community. The experience of the primary care track residents will be even more intense since 10% of their ambulatory office time will be devoted to their projects. The program leadership will help the resident define the problem based upon the Institute of Medicine's six aims (safe, effective, equitable, efficient, timely, patient centered) and will facilitate involvement of other stakeholders. The program leadership will also assure support for data gathering and analysis and create opportunities for the resident to report results to organizational leadership. The resident will also be integrally involved in strategies to "spread" the improved processes more broadly through the organization or community.

Osteopathic Residents in the Primary Care Track Schedule

*Block Curriculum (subject to change)**:***

PGY1

Rotation	Duration (blocks)
General Internal Medicine Inpatient	3
ICU	1
Night Float	1
Cardiology	1
Community-based General Medicine/Berkshire Heights	***2***
AM-A4 Subspecialty Clinics PM-Ambulatory Subspecialties	1
Surgery/Peri-operative Medicine	1
Women's Health	1
ER	1

PGY2

Rotation	Duration (blocks)
General Internal Medicine Inpatient	2
ICU	1
Night Float	1
Cardiology	1
Community-based General Medicine/Berkshire Heights	**2**
AM-A4 Subspecialty Clinics PM-Ambulatory Subspecialties	1
Neurology	1
Psychiatry	1
Elective	2
Geriatrics	1/2

PGY3

Rotation	Duration (blocks)
General Internal Medicine Inpatient	1
ICU	1
Night Float	1
Community-based General Medicine/Berkshire Heights	**3**
Geriatrics	1/2
Rheumatology/Orthopedics	1
Elective	2 1/2
Musculoskeletal Medicine	1
Dermatology	1

Longitudinal Curriculum: Concurrent with block curriculum over 3 years of training

- Continuity Ambulatory Experience at Community-based Practice Site (1/2 day/week once or twice weekly based upon rotation; none during ICU, Night Float, General Inpatient Medicine rotations.)
- QI team project - longitudinal
- Portfolio project - longitudinal

Ambulatory – Berkshire Heights – The resident will train at the community-based practice site for both block and longitudinal experience over their 3 years. The ambulatory curriculum has been expanded to promote a greater depth of knowledge and skill for the spectrum of ambulatory medical problems, with greater focus on the care of patients with chronic medical illness, greater awareness of community resources, greater focus on office team functions, and greater depth of experience in process improvement. "Business issues in health care" are actively incorporated into the training curriculum.

During block rotations, the resident will provide care to his/her panel of patients approximately 8 half day sessions per week and will be involved in process improvement education and implementation 2 half days weekly. Community outreach experiences may also occur during this time. The resident practice occurs in an

office setting along with other primary care providers. Several core clinicians trained in faculty development and process improvement will serve as mentors. The resident will be an active participant in a practice that is developing a medical home model. The resident will develop skills in working in a team with other staff, including physician extenders. The resident will also become aware of organizational changes, resulting from the health system's evolution towards a clinically integrated organization.

Quality Improvement Project – A robust QI training curriculum already exists and is in its 10th year for the internal medicine residency. The Primary Care track residents will continue in this 3-year long longitudinal "learn by doing" program, but will serve in separate teams that will focus on projects relevant to the ambulatory practice sites or community. The experience of the Primary Care residents will be even more intense since 10% of their ambulatory office time will be devoted to their projects. The program leadership will help the resident define the problem based upon the Institute of Medicine's six aims (safe, effective, equitable, efficient, timely, patient centered) and will facilitate involvement of other stakeholders. The program leadership will also assure support for data gathering and analysis and create opportunities for the resident to report results to organizational leadership. The resident will also be integrally involved in strategies to "spread" the improved processes more broadly through the organization or community.

Program Curriculum

The Program Curriculum describes the general goals and objectives of the training program, as well as the overall evaluation methods to assess the competencies including Patient Care and Procedures, Medical Knowledge, Professionalism, Practice-Based Learning, and Systems-Based Practice. The Program Curriculum complements Individual Rotation Curricula. Rotation-specific learning objectives and means to accomplish these objectives are described in the individual rotation curricular document. It is the responsibility of the intern/resident to regularly review the program and specific rotation curricula, and to present the rotation curriculum to the teaching attending on the first day of the rotation so that personal learning objectives may be reviewed in the context of this document. It is the responsibility of the teaching attendings to provide daily formative feedback as well as summative feedback at the midpoint and end of the rotation. It is the responsibility of the intern/resident to use this information, along with other feedback described above, to facilitate a process of continuous improvement. In addition, the resident will provide regular written evaluations of the faculty and program to facilitate continuous improvement of the training program. The resident will regularly reflect on the quality of care provided to his/her patients, and agree to be actively involved in the Hospital's efforts of continuous improvement in quality of patient care.

Didactic Program

Intern Morning Report – This forum will be held from July until September (unless requested to be extended) from 0700 to 0730 to specifically address nighttime logistical, teaching, and ethics issues that may be new to first-time housestaff. It will be led by full-time faculty and the junior faculty in order to review events from the night before and help guide the group through its transition to independence.

Survival Series – Daily midday lectures from July through August focus upon knowledge and skills to manage acute problems that will face the resident during training. Come have lunch, or watch online. All lectures are saved on a common computer server for those who miss, and are broadcast live to Berkshire Heights.

Specialty Conferences – All Monday and Tuesday midday lectures beginning in September are offered by sub-specialty staff. Staff are assigned topics based upon a three-year cycle of subspecialty didactic training goals, defined by the Department of Medicine full-time faculty.

Osteopathic Manipulative Medicine (OMM) – Osteopathic residents will attend monthly OMM conferences as scheduled.

Grand Rounds and Post-Grand Rounds Sessions – Residents will attend all Department of Medicine Grand Rounds and participate in a post-grand rounds hour. This hour is an opportunity for residents and students to interface in a small group format with the visiting professor.

Grand Rounds is required of all residents with the following exceptions:

- ICU resident
- Night Float resident

All other residents are expected to attend Grand Rounds, arriving promptly at 7:30. Students are also required to attend and residents should assure student attendance.

Morbidity and Mortality/QI Conferences – At these sessions, relevant cases are chosen by the assigned upper-year resident with the assistance of the Junior Faculty and Department Chair. The resident develops a patient safety assessment in conjunction with the QI office and Department Chair. (Appendix B)

Chief's Rounds – Once yearly, each intern is expected to present a high-level evidence-based lecture to colleagues. The topic being considered should be discussed with the Junior Faculty Member or Mentor. Extensive literature review is expected. A limited number of educational goals for the audience should be clearly defined. Demonstration of high level skills in the presentation of a lecture topic is expected.

Journal Club – On a monthly basis, an upper year resident will provide a formal critical review of a journal article of clinical import to the audience, emphasizing search strategy, methods and statistical analysis, as well as importance of the article in advancing the field.

Board Review – Dr. Donato and other faculty offer board review sessions twice weekly. Sessions are targeted at seniors and are intended to teach clinical reasoning and test-taking strategies.

Inpatient AM Report – Sessions are held 0700 to 0730 hours on Mondays, Tuesdays, and Thursdays. In the summer months, there are separate intern and upper-year AM Reports. These are consolidated (interns and seniors together) in September. Focus is upon highly interactive, evidence-based discussions of acute patient issues on the inpatient or outpatient resident services. All interns are required to attend the intern AM report, unless there is an approved excuse due to conflicts with another learning experience. All residents assigned to inpatient services are required to attend AM report.

Ambulatory AM Report - Sessions are held from 0730 to 0800 on Tuesdays and Fridays. Sessions are required of all residents on all ambulatory rotations including A4-RH IMP, Ambulatory Subspecialty, RH IMP, Geriatrics, BH, and A4-BH. Sessions include the Yale Review Program, case presentations, and clinical epidemiology training. The primary foci of these sessions are common ambulatory clinical situations, quality improvement, and office management.

QI Project – Residents will spend 18 noon sessions per year creating, implementing, and studying a Quality Improvement measure with their peers. Sessions will take place in lieu of noon lecture. Residents will develop an understanding of the difference between process improvement and research activities, learn the techniques for change including use of PDSA cycle, learn to critically analyze their own practices, learn how to be agents of change within a system, learn how to operate a database and work within a team structure. Meetings will occur on the first and third Thursdays following the completion of the Survival Series.

Simulation Program: Residents will learn leadership in critical situations through the MATT simulation education program. In this program, they will respond to pre-programmed simulations developed from actual cases at Tower Health. They will work alongside a ward nurse, ICU nurse, and a respiratory therapist to lead a team, rapidly develop a therapeutic plan and institute that plan and triage the patient. Faculty include a board-certified simulation driver who is aware of the outcomes of the case and a trained nurse educator who will give feedback during a debriefing session with regards to the performance of the team. The residents, rating will be using a mastery learning model, meaning that residents will continue to come back until it is clear that they have mastered the subject area. Incidence will receive electronic records of their performance, and when certified, they will receive notification that they can perform this service independently (with the caveat that all patients will be seen by an attending in this facility regardless.)

Portfolio – Residents from the program are strongly encouraged to direct their own active learning projects. This will be accomplished through the creation of an online active learning portfolio. Residents are given a series of short introductions to concepts of CV creation, small and large group teaching skills, one-minute preceptor and delivery of feedback, self-analysis of written work, and critical incident analysis discussions. They will also be asked to add to their portfolios as a part of their Night Float curriculum. There will be formative review of the portfolio at least 3 times yearly with the mentor and summative review once yearly with the Program Director.

EKG Training sessions – EKG training sessions are provided by Cardiology faculty twice monthly. A competency examination is offered at the end of each year of training.

Attendance at didactic programs should be at least 70%, although at least 80% attendance is required for Pay for Performance benefits. Staff have received regular education on the importance of resident participation in the didactic conference program. Any pressure from attendings to defer conference for work responsibilities should be discussed immediately with the Junior Faculty Member, Mentor, or Program Director.

The Subspecialty Educational Coordinators and the Faculty meet quarterly to develop plans for the didactic program based upon FCIM curriculum, in-training exam results, and resident and faculty recommendations in order to assure a complete didactic curriculum over a three-year period.

Procedural Competencies

Procedure	No. Required to be certified to perform independently	Recommended time for certification
ACLS training	Determined on individual basis	Prior to start of PGY1
lumbar puncture	5	End of PGY2
knee arthrocentesis	5	End of PGY1
arterial blood gas	5	End of PGY1
abdominal paracentesis	5	End of PGY2
nasogastric intubation	3	End of PGY1
pelvic & breast exams	5	End of PGY1
central line placement	5	End of PGY2
Thoracentesis	5	End of PGY2
Venipuncture	1	Prior to start of PGY1

Procedures required for ABIM certification

Process to accomplish above: Cognitive component of intravenous line placement, obtaining arterial blood gas, lumbar puncture, arthrocentesis, paracentesis, pelvic and breast exams, and thoracentesis will be presented and certified in the intern Orientation Program. Retention of cognitive component will also be evaluated by supervisor of procedure. Orientation session provide simulation/model training in intravenous line placement, arterial blood gas, arthrocentesis, pelvic examination; standardized session at Jefferson Sim Center provides competency assessment with the cognitive and technical skills (model).

Procedures required for graduation by the ABIM/ACOI include: ACLS, drawing venous blood, drawing arterial blood, Pap smear and endocervical culture, and peripheral venous line placement. Performance of these procedures under supervision and certification by the supervisor are required before the resident can be allowed to perform independently. Other procedures are encouraged and some will be required, based upon future career goals.

Rotations offering greatest opportunity for the above experiences are:

- Lumbar puncture – HTS service, ED, Neurology rotation, Procedure block, and On-call.
- Arthrocentesis – HTS, Ambulatory block, Rheumatology rotation, Arthritis Clinic (A4).
- Abdominal paracentesis – HTS.
- NG placement – ICU, HTS, ED.
- Pelvic/Breast Exams – TRH IMP, Ambulatory block, Women's Health.
- Central Lines – ICU, Anesthesia, On-call
- Thoracentesis – ICU, HTS, ED, Procedure block

Supervisors will confirm performance of procedures and document independent function.

Interpretative Skills

Interpretative skills required for ABIM Certification

Skill	Criterion and setting	Recommended time for certification
EKG interpretation	Complete examination – Cardiology EKG sessions	End of PGY2
Urinalysis	Complete CD/exam – TRH IMP office	End of PGY2
gram stain	Complete CD/exam – ID rotation	End of PGY1
peripheral blood smear	Complete CD/exam – TRH IMP office	End of PGY2
Spirometry	Complete exam – TRH IMP office	End of PGY2
KOH/wet prep of vaginal secretions	Complete exam – Survival Series	End of PGY1

In addition the residency will develop sufficient skills to interpret Holtor Monitor reports and Swan Ganz catheter readings. For additional information on basic standards per ACOI visit the following website http://www.acoi.org/doclib/doclib_popup.cgi?file=342-e60d5a40ef0dfef83a8fd27751409007.pdf

After completion of the above exams the resident will log completion into My Evaluations. The supervisor will confirm as well as certify the resident's ability to independently perform each procedure.

Residents as Teachers

"Intrinsic to the discipline are scientific knowledge, the scientific method of problem-solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values" *(Program Requirements for Residency Education in Internal Medicine)*.

It is a tradition of our profession not only to pursue lifelong learning for ourselves, but also to educate those less experienced in the practice of medicine. As a component of professional development, as well as enhancement of communication skills and reinforcement of medical knowledge, it is expected that all residents in the program will serve as teachers for their peers and junior team members. Teaching skills and techniques will be introduced to the residents during specific teaching workshops and modeled on clinical rotations. Interns will practice teaching skills by mentoring medical students as well as by participating in resident conferences and supporting one another in daily patient-care responsibilities. Residents will have gradually increasing responsibility in teaching, so that advanced residents will teach second-year residents, interns, and students, as well as their peers. This may occur during routine patient care or in the form of increased responsibilities during resident conferences and teaching rounds. Residents receive a rolling three-year curriculum on the art and science of teaching, including the topics of Large-group and small-group teaching, one-minute preceptor, learning climate, and applied educational theory. They are given regular electronic feedback for their Intern Ambulatory and Inpatient AM reports, M&M conferences, Journal Clubs, Chief Rounds that they are encouraged to load to their portfolios and reflect on how they would change if they could do it again. They then discuss their interests in teaching and their opportunities for growth as a senior. *(Student responsibilities and framework for evaluation, as well as student interests, are described in Appendix C.)*

Clinical

Ambulatory Medicine

At least one-third of the training experience over the three-year period will be in an ambulatory setting. Regular opportunities for ambulatory training occur through the continuity TRH IMP experience, ambulatory block rotations, in the resident-faculty practice (or assigned private practice) office, and ED rotation. In addition, clinical time may be arranged in specialty offices as separate rotations (such as upper-year cardiology outpatient rotation) or in the context of a subspecialty inpatient rotation. Educational goals are described within the respective curricula.

TRH IMP

Philosophy
Reading Hospital, in its effort to meet the needs of the community, is committed to providing comprehensive health care through its Outpatient Services Department. Anyone seeking the assistance of the Hospital regarding health needs has appropriate and comprehensive care available through this department.

Patient Care Objectives

- To make available to the community quality health care which takes into account the individual's total needs.
- To assure continuity of care by implementing and maintaining a plan of follow-up to include appropriate referrals to other healthcare providers.
- To provide effective health education to patients.
- To promote cooperation and communication among all members of the health team and allied community agencies to avoid duplication of effort and contradiction of goals.
- To provide services in a manner and in a setting that recognizes the patient's dignity.

.

- To provide services with a minimum of waiting time and in a manner that respects the patient's physical and emotional endurance.
- To provide the same quality of health care to all patients, regardless of race, creed, language, or socio-economic situation.
- To provide a milieu for the education of medical students and residents in the provision of high-quality, cost-effective care.

Team Structure at TRH IMP
Since AY 2009-10, the structure of the resident clinic was changed to incorporate team-based care and chronic care model precepts. Residents are divided into teams of approximately ten residents each. The team assumes the care of the patients in the panel. A resident can still be the identified primary care physician, but they are now backed up by a team of physicians who have some knowledge of an individual patient through team meetings. These other team members can then assume care on an as-needed basis. The teams will meet monthly with their team faculty lead, team nurse, team clerical staff, and team social worker to discuss process issues, patient outcomes, quality improvement plans, and to brainstorm around "difficult" patients or problems. The role of the intern on these teams will be to actively participate in team meetings, bringing their experience from other settings/health care systems to the group, to align with the goals of improving ambulatory education and patient care in the resident clinic. In addition to these tasks, the second-year residents will assist the third-year residents in agenda setting, facilitation, and scribing. The third-year residents will be responsible for meeting with the faculty lead and setting agendas for each team meeting, analyzing team patient outcomes, developing quality improvements projects, and setting the "doc of the week" coverage schedule for the clinic (the "doc of the week" is the resident tasked with checking the electronic medical record each day for important messages and labs).

Practice Improvement Plans

At least twice over the course of the year, a resident will meet with a faculty member to develop and review an individualized practice improvement plan. The initial stages will be based on review of patient outcomes of an individual resident's clinic panel, with identification of areas that need improvement. Once these areas are identified, the resident and the faculty member will meet, define a plan to change one's practice patterns to effect an improvement in selected outcomes, and then set a timeline for achieving the identified goals. After an agreed upon time period, but no later than six months later, the resident and faculty member will meet to review the indicators agreed upon, gauge success, and analyze that success or failure at meeting goals. New goals for the next six months will be generated at that meeting, as well. All practice improvement plans are to be uploaded into the ambulatory section of an individual resident's portfolio and reflected upon in their portfolio.

Continuity Medical Clinic (TRH IMP)

Continuity Medical Clinic is held every afternoon. Physician time is 1300 to 1700 hours. This is a teaching Medical Clinic where residents see patients on a weekly schedule. Once a patient is assigned to a resident, the resident will follow this patient's care until he/she finishes the residency or the patient leaves the clinic.

After being registered, a nursing assessment is performed on each patient, which includes the taking of vital signs. The patient is then escorted to a room and assisted into an exam gown when appropriate. The resident is responsible to review the nursing assessment of each patient, and update the problem list and medication list at each visit. After completing the assessment, the resident presents his/her findings to the attending physician.

The resident returns to the patient for closure. The resident will complete any necessary orders in the record, and the clerical staff schedules all tests and follow-up appointments. The resident will complete all clinic notes within 24 hours of the day of the clinic session, and forward these notes to the attending for attending co-signature.

The number of patients scheduled increases with training level. Up to four patients are scheduled for interns, and up to six patients per upper-year resident. The residents are under the direct supervision of a full-time faculty member. Two faculty members serve as supervisor for the year (depending on which day the resident is assigned to the clinic). The supervising faculty shares patient care responsibilities with the resident. The attending physicians are always present during the clinic sessions. All cases should be presented to the attending. Occasionally, when approved by the attending, routine problems need not be presented. However, consistent dialogue between attending and resident regarding some learning issues on most patients is strongly encouraged. The attending reviews every chart of patients seen in each clinic session.

Telephone messages to resident physicians are forwarded to the triage nurse during work hours. The nurses are careful to minimize interruptions to residents. The resident is paged for acute issues. If the resident is unavailable, the nurse will direct the acute problem to the "resident doctor of the week" of each practice team and/or the attending for the clinic that day. After hours, all phone calls are directed to the attending physician on call for RH IMP.

Specialty Clinics

Residents may be involved in medicine and some surgical specialty clinics during the ambulatory block rotations or individual specialty rotations. These clinics are to serve as consultative clinics rather than continuity specialty clinics. Therefore, the majority of patients seen in these clinics should receive ongoing care for the subspecialty problem through their primary care providers. It is important for the resident to refer to these clinics judiciously, clearly posing the clinical question which the resident wishes the subspecialist to address

Logistical Issues in the Medical Clinic

Documentation

Proof of Identity:	Two forms of identification must be confirmed prior to speaking with a patient about any protected health information. Name and date of birth are acceptable.
Vital Signs:	Nursing staff will document this for physician review.
Nursing Assessment:	Physician should review each visit for any problems requiring MD attention.

- Decreased patient level of function
- Pain
- Educational requests
- Weight loss/weight gain
- Domestic violence protocol – when positive, involve Social Service for assistance

Problem List: Must be updated at each visit.

Medication List: Must be updated on each visit.

Visit Notes: All notes for office visits should be completed on the day of the office visit and then forwarded to the supervising attending for co-signature.

Test Ordering: Diagnoses must be included with all tests ordered in order for the test to be done.

Communication

It is important to check your EPIC Inbox on a regular basis every day to prevent late forms or insurance denials.

Most of the time, the staff at TRH IMP will attempt to contact the resident in charge of a particular patient's care. However, each practice team will also designate a "resident doctor of the week" to serve as the contact person for the staff at TRH IMP in case the primary resident for an individual patient is not available.

If residents are forced to cancel or move a clinic because of vacation or away rotations, they should notify the TRH IMP Practice Manager no later than six weeks before the required change in schedule via telephone/Outlook email. If a change needs to be made less than 6 weeks prior to the clinic date, it must be approved by both the Junior Faculty Member and Program Director.

The clinic is not open on weekends. However, with EPIC, all patient notes are available if needed.

Sometimes, urgent medical conditions are discovered during patient visits which require evaluation/treatment by the Emergency Department. At TRH IMP,

- If the patient is stable (severe cellulitis), transportation can be arranged through the nursing staff via "Centran" transportation.
- If the patient is unstable or requires special transportation (ie supine due to severe back pain), nursing will call "911".
- If a patient is unstable and in acute distress (ie, acute coronary syndrome in the office), nursing will call "911" AND the resident calls "Code Blue".

The resident should always call the Emergency Department directly to give verbal handoff.
Patients that are being directly admitted from TRH IMP should be called in to the HTS admitting resident.

TRH IMP Schedule Modifications

ICU ROTATION

- No clinics for any resident on ICU rotation.
- Four to five residents per block will be on ICU rotation.
- Residents on ICU rotation should be paged only after 1300 hours unless there is an emergency. (Page only if really needed.)

NIGHT FLOAT ROTATION

- No clinics for any resident on the Night Float rotation.
- There will be one upper-year resident and one intern per block on Night Float rotation at any given time.

- These residents should not be paged under ordinary circumstances. If you must page them, do so first thing in the morning at 0700 hours.

HTS ROTATION
- No clinics for any resident on the HTS rotation, with rare exceptions.

AMBULATORY CONTINUITY PRACTICE ROTATION
- Residents will be seeing patients in their longitudinal clinic Monday thru Friday afternoon during this rotation. The rest of the rotation will be spent doing A4/A3 Subspecialty Clinics.
- One or two residents per block will be on this rotation.

Subspecialty Clinics
Residents will receive a schedule of the specialty clinics in which they will see patients under guidance of a subspecialty attending. These specialty clinics are:
- Cardiology
- Dermatology
- GI
- Pulmonary
- Infectious Disease
- Arthritis
- Endocrine
- Neurology
- HIV

TRH IMP Late Policy
Please check with the medical resident or attendant before registering the following patients:

- Any patient who arrives 15 minutes or more after his/her scheduled appointment.

The resident or attendant will determine if it is possible to see the patient, or if he/she needs to be rescheduled.

After permission is obtained, the patient may be registered.

No-Show Policy for TRH IMP
- Patients will be given a written warning after a missed visit.

- If the patient “no-shows” for an appointment after receiving an initial warning letter, a written warning will be sent via certified mail. The patient may reschedule or cancel up to two consecutive times after receiving the warning letter.

- If patient fails to show for an appointment after the certified warning letter is sent, a letter of termination will be mailed via certified mail.

Influenza Vaccine/PPD Testing Protocols
- Annual influenza vaccines may be administered to all patients, regardless of past influenza vaccine history.
- Annual one or two-step tuberculosis testing via intradermal PPD administration is an acceptable practice for all patients as required by an employer or other outside source. There are no contraindications for receiving TB testing.

TRH IMP Medication Refill Policy
When a patient calls for a medication refill between scheduled appointments, adherence to the following policy applies:
- Verify medication name, dose, and frequency.
- Verify current order for the requested medication(s).

- Confirm the patient's pharmacy and phone number.
- Assess the patient's compliance history with appointments.

    - If the patient has a history of good compliance, a one-month supply with up to 11 refills may be called in, depending on each individual pharmacy's policy.
    - If the patient has a history of poor compliance, call in for a one-month supply of medication with just enough refills to last until the patient's next scheduled appointment. (This is done to promote compliance.)
    - Controlled substances are handled on an individual basis, and require DEA approval from an attending physician.

TRH IMP Policy Form Completion

- Patients should allow 10 to 14 days for completion of any form to be filled out by a doctor.

- Forms should be brought to the office at the time of the patient's visit, or should be dropped off to the staff.

- If the patient's PCP resident will be attending clinic the week that a form is dropped off, the patient's EMR records will be flagged and this flag forwarded to the resident physician.

- If the doctor is not in the clinic that week, the form will be forwarded to the team's "doc of the week" to be filled out or deferred to the PCP depending on urgency.

- Any form that requires an attending physician's signature will be given to the attending the next time he/she is in clinic.

- All forms should be given back to the RH IMP staff before mailing so that a copy can be made for the patient's chart.

TRH IMP Policy for Outpatient Laboratory Results

- Lab results will be automatically transmitted into the EMR for the residents to review. If the physician provider for a particular patient is not available, the "resident doctor of the week" for that provider's team will review the results and take appropriate action.

- Residents should check their EMR in-boxes frequently, and should sign off on labs and communications in a timely manner. NOTE: ALL RESIDENTS ARE REQUIRED TO GO INTO THE EMR ON A DAILY BASIS TO DO THIS, WITH THE EXCEPTION OF RESIDENTS ON NIGHT FLOAT, ICU, OR AWAY ELECTIVES.

Inpatient Medicine

Resident Responsibilities and Supervision

The policy on resident supervision is provided in Appendix E.

The resident is responsible to carry out the duties defined in the curriculum for each inpatient rotation.

Residents have an assigned teaching attending for every inpatient and ambulatory experience. The resident is responsible at the beginning of each rotation to inform his/her attending of all planned absences (vacations and conferences). On teaching services with first-year and upper-year residents, the first-year resident will utilize the upper-year resident as the first line of supervision as coordinated with the attending physician. Residents have the primary responsibility for patient evaluation, problem definition, and plan development for further evaluation and treatment, including appropriate documentation. The attending physician is ultimately responsible for the care provided to all patients on the service.

Teaching Rounds: Teaching rounds are made with the attending each weekday as described in each rotation's curriculum. Teaching rounds may be independent or merged with management rounds. The teaching component of rounds must occur at least three days per week for a minimum of 4.5 hours per week and must include bedside teaching by the attending and observation by the attending of resident interaction with the patient.

Patient Load: No first-year resident will be responsible for admitting more than five (5) new patient admissions plus two (2) transfers (total 7) in a 24-hour period. A second-year or third-year resident will not be responsible for admitting more than ten (10) new patients and four (4) transfer patients per admitting day, or more than sixteen (16) new patients in a 48-hour period. This policy applies to all inpatient teaching experiences. Admissions are defined as patients admitted to the hospital or observation unit, as well as transfers from non-medical services (surgery, psychiatry, rehabilitation centers). Transfers from ICU or other medical teams do not count as admissions unless the number exceeds two (2) patients. Patients admitted to the service by Night Float count toward assigned patients but not as admissions. PGY1s will not be required to provide ongoing care for more than ten (10) patients; PGY2s or PGY3s will not be responsible for ongoing care of more than fourteen (14) patients if supervising one PGY1, or twenty (20) if supervising more than two PGY1s.

Back-Up: Internal Medicine special requirements define maximal number of patients that may be admitted or may be continuously under the care of an intern or upper year resident. In situations in which these numbers are exceeded, the appropriate hospitalist involved with the teaching service will handle the excess admissions. It is the responsibility of the attending physician to make appropriate arrangements for safe care of the patient and for guideline adherence. In any circumstance when the resident does not feel capable of safely handling admission or ongoing care responsibilities, the attending physician should be promptly notified so that adjustments can be made to assure patient safety and to avoid undue resident stress. A Jeopardy system is in place to address unusual system overload. Jeopardy residents would be called in to assist on-call residents, when deemed appropriate by the on-call faculty member.

When a patient is being considered for direct admission from the Continuity Clinic, the clinic resident or attending should call the HTS admitting team (either the upper level resident or the attending) to present and discuss the proposed direct admission.

Admission history and physical should be completed within 12 hours of admission and discharge summary should be completed by any team member within 24 hours of discharge. On the Hildreth Teaching Service (HTS), the PGY1 resident will complete the discharge summaries on all patients at the time of discharge (very strongly encouraged) or no later than 24 hours after discharge, but preferably at the time the discharge order is written. The use of structured discharge forms ('dot phrases') is strongly encouraged. The upper year or attending may occasionally assist in this function, in order to assure efficient patient care. On other teaching services, the discharge summaries will be dictated as arranged with the attending physician.

The resident should write all the orders on patients unless an emergency situation dictates that others on the team write orders. It is expected that the PGY1 will write all progress notes on patients unless circumstances (workload issues) require assistance from the upper-year resident. In that case, the PGY1 should see the patient, but would not be required to write a note in addition to the senior resident progress note.

Residents will carry out the management for each of their patients under the supervision of the attending physician. Daily progress notes will document the management and the thought processes leading to diagnostic/therapeutic decisions.

Documentation: Residents on HTS, NF, and ICU are expected to complete daily progress notes, H&P's, and discharge summaries for any patients they are assigned. They are prohibited from copying medical records from other providers and inserting that information in their own notes. They can copy their own notes (i.e. for daily progress notes) with the expectation that they are updating the note with any relevant information on a daily basis. This will include adjusting the subjective assessment, physical exam, labs and any relevant changes to the assessment and plan. If residents are not appropriately and accurately updating progress notes that were copied from previous days, then their attending may require them to write original notes on a daily basis.

Residents will concisely present each new patient to the attending physician as well as develop and review an appropriate diagnostic/therapeutic plan including issues related to discharge planning when appropriate. The schedule for attending rounds will be directed by the attending physician.

Residents are expected to develop clinical questions on a daily basis and review appropriate medical knowledge sources, in order to provide most current evidence based care. In addition, residents are expected to develop a spirit of inquiry and skills to develop questions for quality improvement and research studies.

The resident will follow standard sign out policy to assure consistent transfer of patient information and update in EPIC and orally to team.

A sincere effort to obtain postmortem examination is to be accomplished on every patient who dies while under a resident's care. In order to promote practice-based learning, the resident should attend any autopsy performed on one of his/her patients and review the findings with the HTS attending. The resident will document attendance at the autopsy, and review of the final autopsy report in My Evaluations under the Procedure Logger section.

Non-teaching service patients

The appropriate attending physician will care for non-teaching patients. "Non-teaching patients" are defined as those individuals not receiving ongoing care by the HTS service or resident ICU team, and not assigned to a resident on a specialty service for ongoing care by a medical resident. Residents will not be responsible for routine care of non-teaching patients, but may be called upon to respond to acute emergencies in the form of MATTs and Code Blue situations.

Assigned resident teams will respond to Code Blue throughout the Hospital. Rapid Response or MATT teams respond to urgent pre-arrest problems. The attending physician of record will assume responsibility for ongoing care of these patients within 45 minutes, as documented in the Medical Staff Bylaws. Residents will cover MATT teams in R-building (including R1, R2, R3 and R4) from 7 a.m. to 7 p.m. Patients cared for by MATT teams will have their care handed off to the attending of record as soon as that attending can be available.

Specific expectations for interns and residents on the HTS Medicine Teaching Service are as follows:

HTS

Interns:

1. AM sign out. Pull up list on EPIC. Move patients to the proper intern; if interns are off, senior will assign themselves that patient.
2. All patients should be seen as soon as possible. (review labs and see the patient, order appropriate tests or discuss changes in condition with upper year. Notes may be done later, do not delay evaluating or treating your patients just to do a note.)
3. Replete all electrolytes and identify newly sick (by labs and vitals) by the time the team meets to discuss overnight issues and receives signout from night float.
4. Discharge orders should be placed prior to 11 am, if possible, for those known to be going home that day. Text page attending notifying them that order has been entered so that can be reviewed in an expedited manner.
5. Keep cross-cover information current in EPIC. This includes code status.
6. Maintain passwords for all computer programs. Review the outpatient EMR on all patients assigned to these clinics.
7. In the ED, enter patients into EPIC promptly, preferably while the patient chart is in front of you.
8. Assign each patient to an intern at NF signout on paging system, or to a senior if the intern is gone.
9. You are responsible for the daily update of your signout of your patients to the on-call intern; you will be watched and given feedback on this until you can do successfully.

Resident:

1. Computer rounds with attending M-F following AM sign out. Discuss thought process and plan for the day.
2. When you are called by ICU team to pick up a patient, get the patient information and enter them into EPIC as yours on your list at that time. You may wish to flag that person in the "To Do" section as take over care when moved out of ICU if applicable. Enter all relevant signout information that the ICU team provides you.

3. When you are notified of a consult, enter the patient information in EPIC and any information about the clinical question and case at the time you are called. This applies even if you are told that the patient does not need to be seen until the next day. Enter the information at the time you are called.
4. Respond promptly to the ED. Place order for admission as soon as it is apparent the patient needs to come in. It is no longer acceptable to delay decision on disposition and order entry by hours.
5. Review patient list in EPIC make ensure your census list is accurate. Review sign out information and provide feedback to interns regarding accuracy of active issues and reasonable level of detail.
6. Notify attending of quality issues or patient care issues. Please be able to provide patient name, Medical Record number, and name of hospital staff involved (if applicable.)
7. Maintain passwords for all electronic media. Review the outpatient EMR on all patients assigned to these clinics.
8. Identify the sickest patients and round with the intern on those patients first.
9. Communicate with family (phone call or meetings) in cases where the patient is unable to keep them informed (ex. Dementia, aphasia.) Do so daily, and communicate that this was accomplished in your note.

Quality Review

All deaths on the teaching service will be reviewed by involved residents and attendings. In addition, any death or adverse occurrence that raises a quality concern will be reviewed by the Resident Peer Review Committee and the findings will be presented to the Department of Medicine Quality Improvement/Patient Safety Peer Forum.

Resident Peer Review Committee Charter

Goals

The resident Peer Review Committee will be a subcommittee to the Department of Medicine Peer Review Committee. The goals will be to review HTS and resident index cases as determined by the QI department as is done for the DOM Peer Review Committee. The resident committee will perform patient flow and root cause analysis and determine if standard of care was met. The Department of Medicine Peer Review Summary will be completed (see attachment A) and the recommendations for improvement will be agreed upon and presented to the DOM Peer Review Committee by the faculty representative. The Junior Faculty Member will also present the findings and recommendations to the residency director. The review summary form will serve as minutes for the meeting.

Members

The committee will consist of the faculty member who sits on the DOM Peer Review Committee, the Junior Faculty Member, and resident representatives from each of the 3 years (5 members in total.) Members from the prior academic year will have the option to stay on for the next year starting in July. The Junior Faculty Member is ultimately responsible for assigning members if volunteers are lacking. If another resident from the same year expresses interest in being on the committee for the next academic year, the current resident from that year would be replaced and not given the option to stay on but could serve as a back up to one of the 3 members if a scheduling conflict were to arise. This will allow additional residents who are interested an opportunity to participate in the process. A quorum will consist of the faculty member, and at least 2 of the residents.

Scheduling

The committee will meet every other month on months alternating with the DOM Peer Review Committee. Presently this means the resident Peer Review will meet Jan, Mar, and May for this academic year. We will meet the 3rd Tuesday at noon on the months indicated. Members will be excused from the noon lecture and given credit for participating in the Peer Review Committee on those days. The day was chosen so as not to conflict with Chief Rounds, EKG teaching, or board review.

M&M Conference

Upper year residents will work with the Chair of Medicine to define sentinel cases that warrant analysis through M&M sessions as described in Didactics Section.

Day to Day Quality/Safety Issues

Residents are strongly encouraged to report any patient quality/safety concern. This can be done through RL Solutions, by calling the Anonymous Incident Reporting Hotline 484-628-9600, or by filling out a Department of Medicine Incident Reporting form (available in the B-2 Medical Education Room).

Core Measures
Core quality measures for the HTS Teaching Service team are collected, compared with benchmarks and reported to faculty and residents for review and consideration of ongoing performance improvement.

Other Inpatient Policies and Procedures

HTS Patient Admission Policy to Critical Care Units
In order to optimize teaching and the provision of quality patient care, the following process has been established:

- All ICU admissions, with the exception of primarily cardiac admissions, will routinely be admitted to the intensivist services. The ICU resident on call will admit patients to the resident ICU team under the supervision of the attending intensivist. The ICU resident on call may participate in the acute care of patients admitted to the non-resident team if it is felt to be of educational value and it does not interfere with the quality of patient care or education.

- On rare occasions, when there has been or will be a difference of opinion about the need for an HTS patient to be admitted to a critical care unit, the HTS attending physician responsible for the patient may choose to admit the patient to the unit on the HTS service under his/her name as the attending physician. The appropriateness of that admission will later be reviewed with all concerned.

- All HTS patients who have a cardiac diagnosis as the principal reason for admission to the Intensive Care Unit will be admitted by the HTS team. The team will request cardiology consultation as appropriate. The HTS team will write all orders, short of peri-procedural orders. Direct verbal contact between cardiology services and HTS service will lead to optimal patient care under the direction of the resident team, with an emphasis on educational principles as well as management issues.

Process to move unstable Inpatients to the Medical ICU
In order to assure rapid transfer of unstable patients to the ICU the upper-year resident will contact the Nursing supervisor.

EMERGENCY ROOM HTS COVERAGE (June 2017)

1. HTS will evaluate for admission patients that present within 30 days of discharge from the HTS service. **Each readmission** will count toward the every eighth admission rotation. We will also admit a patient when a medical resident evaluates a patient in the faculty IMP practice and the patient requires direct admission. This patient will be admitted to the HTS service and credit in the rotation will be given. A patient that has been on the medicine consult service or an HTS consult that is discharged and returns to the hospital will go into the general admitting pool. Likewise, a patient that has previously been on the HTS service that later is admitted with a medical consult placed will be evaluated by the consult service.

2. From 1 PM through 7 AM, HTS will evaluate for admission every **eighth** patient in a rotational basis, regardless of referrer or insurance status (frequency subject to change based on census). The first patient in rotation will be assigned at 1 PM.

3. True Code Blue calls (those that require patient management, not including those that are rapidly triaged to the ER) and MATT calls (in R building from 7A-7P that managed through completion) will count toward the every eighth rotation up to two per each shift (7A-7P and 7P-7A).

4. On the overnight shift 7 PM to 7 AM, the hospitalist that staffs an HTS admission will count one spot in the admission rotation.

5. Stroke patients the require TPA will be admitted to the ICU.

6. HTS will be responsible for psychiatry consults on patients transferred from the HTS teaching service to the Spruce Pavilion.

7. HTS will be responsible for step downs from the ICU that are patients they have evaluated prior to going to the ICU.

8. Patients referred to HTS that have not been evaluated and admitted (including H&P) by the night float team prior to 0730 will be assigned to the incoming admitting team for the day.

9. When the hospitalist team inadvertently admits a patient that would normally go the HTS team (readmit), the hand off is expected to occur by the next working day (not thereafter). The patient will go to the team that cared for the patient during this rotation block. If the patient has not been cared for by either team, the patient will count as an ICU step down and go to the admitting team for the day.

10. When a readmission occurs within 30 days of discharge, the team initially caring for the patient will be responsible for evaluating and readmitting during the day shift (up until 330 PM).

11. HTS Census Guideline

Low Census:

When the **post-admitting team** has a census of **8 or below** or if the **combined HTS** census does not reach **seventeen,** HTS will assume one of the hospitalist general pool admissions from the night before. The night float upper year should be alerted at the start of their shift anytime the admitting team has fewer than eight patients. The night float resident should page the hospitalist census administrator by 0615.

High Census:

When the HTS service has a **combined morning census of 30 or more:**

30-31 consider skipping the first two admissions at 1 PM
32-33 consider skipping the first four admissions
>33 consider skipping all admissions until the night float starts at 6 PM

I suggest calling in the morning by 10 AM to discuss with the administrator what the plan will be for the day.
After a plan is set you should call 8219 and inform the ER facilitator of the plan for the day.

12. The IM resident team will run MATT calls on select floors during the hours of 7:00 AM and 7:00 PM, seven days a week. They will be supervised by the on-call attending for HTS. The proposed floors will include all of R building. The on call resident team may electively participate in all MATT calls from 7:00 PM until 7:00 AM. The on call hospitalist will be expected to lead these calls with assistance from the resident team. The resident team should confer with MATT call leader prior to leaving the scene.

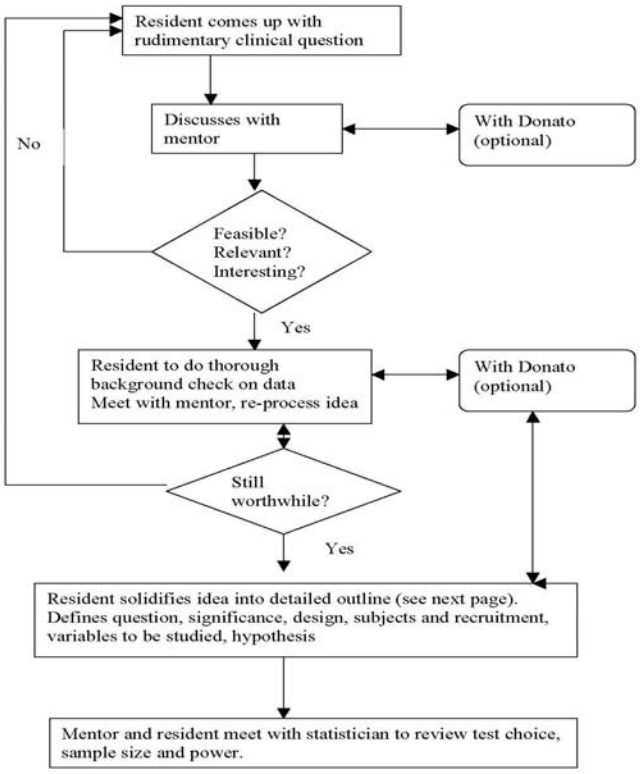
Scholarly Activity

The policy for scholarly activity requirements is included in Appendix F.

Research Block

Many residents will take the Research rotation once during one to three years of training. Pre-requisite planning is described in the Research Block Curriculum. For residents with a special interest in research, the elective may be taken on more than one occasion. In that case, a deeper level of involvement is expected and program director support is required. Most will NOT take a Research block in intern year and it is generally not recommended for interns.

A PGY2 resident should be able to read and understand the medical literature, to reproduce basic study design, to know how to utilize basic statistics, to seamlessly integrate electronic resources, and to develop a knowledge and understanding of IRB's, research ethics, database management and research team integration.



At the completion of the rotation, in addition to the objectives for a PGY2 resident, a PGY3 resident should be able to use the above skills to reach the written manuscript phase.

There is a component of the Pay for Performance incentive that is tied to scholarly activity. See Appendix S.

Resident Clinical Hours and Work Environment

Clinical Hours Policy

The Department's Clinical Hours Policy is described in Appendix G.

On-Call Duties and Back-Up

Upper-Year Residents
HTS Admissions: The upper-year resident, along with the supporting intern, is responsible for all admissions to the HTS team between the hours of 1800 to 0800 on Night Float. The upper-year resident will evaluate every patient that the ED requests be considered for admission. The upper-year resident will provide supervision to the intern/students regarding the admissions, accommodations, or discharge process. The upper-year resident will contact the supervising attending with admissions as outlined in the Supervision Policy.

Outside Calls: The upper-year resident is responsible for answering all calls from patients after the clinic has closed.

Assisting Interns: Day cover interns will call the on-call upper year pager found on the paging system for immediate upper-year support of urgent problems on non-teaching service patients. The upper-year resident will be available to assist interns with any issues that may arise.

Consults: It is the upper-year Night Float resident's responsibility to evaluate any urgent consult that is placed between the hours of 1800 to 0800. For consults placed in Spruce Pavilion, the upper-year resident may ask one of the interns to evaluate the patient, and present the patient to them.

Code Blue: The upper-year resident is in charge of all Code Blue calls. This includes not only following the ACLS algorithms but also directing/delegating responsibilities to the entire code team (interns, respiratory therapists, nurses, IV team, lab team). The upper-year resident must also contact the attending of record, and assist interns in transferring the patient to the ICU. In general, it is the attending's responsibility to contact the family. However, if family members are present during the code, the attending may request that the upper-year resident to speak with the family. Lastly, the upper-year resident will clearly document on a Code Blue Template in EPIC. At the end of each Code Blue, the entire code team will review the code (what rhythms were encountered, ABG review, what went well, what could have been better). This process is subject to change.

Weekend Coverage: During weekends, the upper-year resident on-call is responsible for all of the above during the hours of 1600 to 0800.

Interns
Code Blue: All on-call interns are expected to promptly respond to Code Blue calls. Upon arrival at a Code Blue, the intern should assess the patient and begin ACLS (airway, breathing, circulation). When the upper-year resident arrives, the intern should give a brief description of what has occurred. At that time, the upper-year resident will begin directing the code. In general, interns are responsible for chest compressions and obtaining an ABG, but all should be aware of the rhythm on the monitor and be ready to point out any changes in the rhythm or pulse. At the end of a code, the intern is responsible for helping the upper-year resident transfer the patient to the ICU. If the patient does not survive, the intern is responsible for the death pronouncement and for completing the death certificate. At the end of each Code Blue, the entire code team should review the code (what rhythms were encountered, ABG interpretation, what went well, what could have been done better).

Calls for Non-Teaching Patients: The resident's principle role in the care of non-teaching patients is response to Code Blue or to Rapid Response Team (MATT), if the resident is assigned to one of these teams. The resident may assist with Death Pronouncements when the attending physician is not available within the institution. The on call resident also supports the Hospital's Restraint Policy.

1. Code Blue/MATT Calls – response to Code Blue is an important learning situation for residents; we have historically and will continue to provide leadership in this area. The internal medicine resident team has provided leadership for nearly all Code Blue calls. Possible exceptions occur when an

involved ACLS-certified cardiologist, intensivist, or anesthesiologist chooses to run the code. In these situations, the internal medicine team will assist with the code. The Reading Hospital Rapid Response Team is called the Medical Assessment and Treatment Team (MATT). In the R-building, the IM residents will run the MATT calls from 7:00 AM to 7:00 PM, seven days a week. They will be supervised by the on-call attending for HTS. The IM residents may participate in the evenings from 7PM-7AM seven days per week in MATT calls under the leadership of the hospitalist. As of Spring 2016, up to two MATT calls and/or Code Blue calls can be counted in the admission rotation for each shift (7AM-7PM or 7PM-7AM). This is provided we continue to lead the code call until the end and it is not simply a triage to the ER. This is subject to change.

2. Death Pronouncement – Historically, residents provided this function for all patients in hospital. This has evolved. Because hospitalists and intensivists are in hospital 24/7, they provide this function for their patients. Family Medicine and Obstetrics/Gynecology Residents would be expected to serve this function for their respective services. We will continue to offer this uncommon service to other private physicians, when the covering staff person is not present in the hospital. This would include the rare circumstances when a patient dies on a Surgical Service, private specialty medicine service, or the internal medicine service of Dr. Nader Rahmanian, and no attending is present in the hospital. If the death is expected, the nurse on the floor should contact the covering physician to inform him/her of the death. If it is unexpected, the resident should contact the covering attending physician to explain the circumstances surrounding the death. It is the attending physician's responsibility to notify the family and request autopsy- note that if family members are present, the resident has the responsibility to speak with the family and express his/her condolences.
3. Death Certificates – These are to be filled out by residents only on HTS patients; unless there is urgent need, these certificates should be reviewed with the HTS daytime attendings prior to "sign off" and release of body.
4. Permission for emergent blood transfusion for patients not on a teaching service - this is not generally viewed as a responsibility of the resident. If an unexpected situation arises, where there is immediate risk to the patient, we ask the resident to cooperate, but we wish to monitor this closely and be assured that the assistance is not abused.

ICU Call: Residents assigned to ICU call will follow the assigned schedule. The on-call resident will admit patients to the resident intensivist service under the supervision of the on-call intensivist. The intensivist will become immediately aware of all admissions, and will define the level of responsibility of the admitting resident.

Jeopardy Call Responsibilities: In the event the on-call resident is unable to perform their duties due to sickness or a personal emergency they are to notify the Junior Faculty Member immediately. The Junior Faculty Member will then notify the resident listed for jeopardy call to then take over call responsibilities. The residents are responsible for identifying which dates in the year they are listed as jeopardy call. This schedule will be provided to them in advance by the Junior Faculty Member. If on jeopardy call, the resident is required to be within a **45- minute driving distance** of Reading Hospital and to have phone access at all times. The jeopardy resident is responsible to update the Junior Faculty Member with any changes to their contact number. Before each block the Junior Faculty Member will email the residents on jeopardy call as a reminder of their upcoming responsibilities. The residents are then required to confirm receipt and understanding of their call responsibilities by responding to the email.

Moonlighting Policy

The modified policy on moonlighting is provided in Appendix H.

Evaluation

Evaluation of Residents

Global Assessment – summative and formative evaluation is a component of each rotation and the continuity experience. The attending will offer formative feedback on a regular basis. He/she will meet with the intern or resident on the first day of rotation, mid rotation, and at the end of rotation, at which time a summative evaluation will be provided. A global assessment of resident function which includes patient care, medical knowledge, practice-based learning, interpersonal communication skills, professionalism, and systems-based practice will be completed by the attending, and will become a permanent component of the resident's file. It is expected that average ratings will be five or above on a 10-point scale. Below average rating would not be viewed as a satisfactory completion of that rotation, and will require remediation to be defined by the Program Director. Milestones-based assessment forms will soon be used for all rotations to provide more specific feedback.

OSCE – all interns will participate in an observed structured clinical evaluation (OSCE) in the fall of the internship year. This will assess interviewing skills, communication skills, and aspects of professionalism. Components of the OSCE will be reviewed by the Mentor and other staff, and formative feedback will be provided by the Mentor. Major deficiencies might prompt a need for remedial activities.

Direct Observation – Regular evaluations of resident performance during interactions with patients and colleagues will be carried out by attending physicians on the HTS, TRH IMP, Geriatrics, Palliative Care, ID, Endocrine, ICU, Cardiology, and Nephrology. A total of at least 4 evaluations per month rotation are expected. These evaluations will deal with aspects of patient care, interpersonal and communication skills, professionalism, or systems-based practice. Standard forms will be utilized. Formative feedback will be provided, and these observations will also serve as a component of the global rotation evaluation. (Provided in Appendix J)

Surveys – A nursing survey of the resident's performance in the TRH IMP Clinic will be obtained twice yearly. A patient survey of resident performance will be obtained once yearly. A survey will be completed by peers, ED Nurses, and case managers for residents on the HTS rotation. Full-time faculty will meet at least once yearly for the purpose of feedback for 360° evaluation. Patient and nurse surveys will assess competencies, including patient care, interpersonal and communication skills, and professionalism. Feedback will be provided by mentors, and will serve as a component of the report to the Program Director. Consistent deficiency could prompt a requirement for remedial action. (Appendix N)

Procedures – Procedure documentation will be maintained through the My Evaluations system. Interns and residents are expected to meet procedural goals for their year of training. Mastery of the procedures required of medical residents by the American Board of Internal Medicine is a component of the patient care competency. It is expected that the resident will take responsibility for appropriately documenting procedures performed, and notify the Chief Resident, Mentor, and Program Director of needed procedures in order to meet requirements in the allotted time. Procedure competence is a component of the Patient Care Competency.

In-Training Examination – All internal medicine interns and residents are required to participate in the in-training examination on a yearly basis. Although not used as a criterion for promotion, information will be considered in the context of other ratings of the resident's medical knowledge.

Lecture Attendance – It is expected that all internal medicine interns and residents will maintain an average attendance at conference of at least 70%. These measures will be reviewed quarterly with the Mentor, and uncorrected attendance problems will become a component of the report to the Program Director. Attendance at lectures reflects competencies of medical knowledge and professionalism.

Record Completion – Reports of the resident's timeliness of completion of medical records will be forwarded to the Mentor and Program Director. Consistent tardiness of record completion could prompt required remedial action by the Program Director, including potential loss of vacation time in order to correct the deficiency. Note

that documentation is an important component of patient care, communication skills, and professionalism competencies.

Portfolio – Residents will be asked to detail a permanent record of their education at this facility through the creation of a learning portfolio. The resident portfolio is a collection of documents that captures aspects of learning that are otherwise difficult to assess, and residents will be asked to self-assess these attributes with assistance from their mentor. The chapters of the portfolio require residents to perform and update their own Curriculum Vitae, self-evaluate their performance on AM reports, chief's rounds, and morbidity and mortality conferences, update their research and scholarly activity efforts, reflect on their rotation evaluations, evaluate their written documentation and mini-CEX feedback, and record their answers to evidence-based questions. Residents will be given one hour each month to review a skill needed for reflection and then write in their portfolio. Residents will enter and reflect upon their ambulatory practice improvement plans. Residents will also add reflections to the portfolio during their Night Float block as a part of the curriculum. Residents will have their portfolios reviewed formally three times per year during mentoring sessions. A summative assessment will be included as part of their year-end review with the Program Director in May/June. The portfolio will remain in their possession when not being reviewed, and will leave with them upon graduation. All information that a resident feels is potentially sensitive may be withdrawn at the discretion of the resident. Practice-based learning and improvement will be assessed by this method. (See Appendix A to review the questions mentors will seek to answer during the review of the portfolio.)

QI Project – All residents will participate in a year-long Quality Improvement project of their selection. Residents will participate in team meetings in lieu of noon lecture twice a month on Thursdays. Resident team leaders will be individually mentored by a staff member. Groups will learn the basics of performing quality improvement projects, identify areas for improvement in the institution, and institute a change process utilizing PDSA cycles and the Nolan Model for Process Improvement. Categorical residents will be given increasing levels of responsibility for the project based on year of training. Concepts of data collection, basic statistical analysis, and working as a team will be stressed. Groups will be expected to produce a plan for a PDSA cycle by mid-year, and a performance report by the end of the year. Top projects will be presented to the institution in a Grand Rounds setting. Both practice-based learning and improvement and systems-based practice skills will be addressed.

MATT Simulation- residents will practice simulated MATT scenarios while on inpatient services on Tu/Th at 0900 and Weds at 1600. They will participate with a floor nurse, an ICU nurse, a respiratory therapist in the scenario, and will receive debriefing from a nurse educator as well as a physician educator. Residents will participate in a mastery learning model; that is, they will continue to come until seen as proficient by their instructors (usually 4-10 scenarios).

Advancement

Progress from the first to second and from the second to third years requires satisfactory levels of performance as measured by the Evaluation Tools described above. Based upon these measures, there must be consensus on the part of the faculty that the intern or resident has acquired a passing level of knowledge, skills, and attitudes as enumerated above under Criteria for Advancement.

Due Process

Approach to Remediation, Academic Supervision and Dismissal are described in the Hospital's Resident Manual.
The Internal Medicine Residency Program policies for remediation, academic supervision, dismissal, and grievance conform to the Institutional policies as stated in Part I of the Resident Manual.

A recommendation for dismissal would be made by the Program Director to the Department's Clinical Competence Committee. The affected resident has a right to be present at the committee meeting for that discussion. If the Clinical Competence Committee concurs in the recommendation and the resident wishes to appeal that decision, the resident would notify the Hospital's Medical Director (or Director of Medical Education at TRHMC), and an appeal would be arranged by the Medical Director or DME.

Evaluation of Rotations and Faculty

At the end of each rotation, the resident will complete the end-of-rotation evaluation and faculty evaluation forms. A separate form will be completed for up to three faculty members with whom the resident worked most closely during the rotation. In addition, an evaluation of the Continuity Clinic experience will be performed twice yearly.

Graduate/Employer Survey

Graduates of the program will be surveyed one year after completion of training.

Employers of recent graduates will also be surveyed. *(See Appendix K.)*

Evaluation of Program

Three to four weekly and one monthly meetings of faculty, as well as monthly resident meetings, provide a regular forum to discuss specific and general issues regarding the program. Minutes are maintained of faculty meetings.

Mentor reviews with each resident will occur at least three times per year, and the Mentor will provide a report of these meetings to the Program Director and faculty twice yearly at monthly staff meetings. In addition, a yearly resident retreat is held to discuss areas for program improvement.

Residents complete an annual evaluation of the program. A Yearly Program Review for continuous program improvement follows a format as outlined in Appendix L.

Appendix A – Mentoring Session Worksheet

Mentoring Session Worksheet Version 10 (3/14/14)

Fall Winter Spring

Date of Session ____/____/_____

Resident _____ **Mentor** _____

Year ____ Track_____

Competencies reviewed: Professionalism Interpersonal Communication Problem-Based Learning
Patient Care Systems-Based Practice Medical Knowledge

Long-term career goals:_____

Outstanding issues/'To do' from last session: (**Tab #I** in mentor binder)

1. 4. 7.
2. 5. 8.
3. 6. 9.

Portfolio review

CV (Chapter 1) (each session) (Tab #II) is [] updated and complete [] needs refreshing [] not done
[] on a committee (from CV? (name)_____(required for D.O.'s)

Scholarly activity (Tab #III): AM report/Chief's Rounds/Research (Chap. 2-4 (each session)
Recent Scholarly activity uploaded (**Chap. 2/3**): (topics listed below)

1._____ 2._____ 3. _____
Teaching abilities: rudimentary skilled mastery level
Next steps for teaching:_____

Research interests/ideas (**Chapter 4 Second yrs, Fall**):

1._____ 2. _____ 3._____
Research abilities: basic advanced
Next steps for research:_____

Resident as Teacher (Chapter 9 Third years, Fall)
[] not reviewed [] Reflections present? YES NO
Action Plans:_____

OSCE/Videotape Review (Chapter 5 - Interns, Fall) (Tab #IV)
[] not done this session
[] review completed
Action plans from video: _____

Medicine Rotation Evaluations: (Chapter 6 each session) (Tab #V) Are key comments reflected on?
[] reviewed with resident, no major action items YES NO
[] deficiencies seen, resident plans following actions:
_____
[] Scores from rotation pre-tests/post-tests reviewed

Specific comments worthy of reflection from rotation evals:

360° Evals (Nurse/Peer/Social work) Assessments (Chapter 6) (each session) (Tab #V)
[] peers/ancillaries noted no major deficiencies.
[] Peers/ Nurses noted some issues with (timeliness/ professionalism/ communication/_____)
[] the following interventions were recommended:
_____

Patient evaluations were reviewed with the resident. (Categorical, Winter/Spring, paper) (**Tab #V**)
[] Patients noted no major deficiencies in resident care.
[] A trend toward deficiencies in (listening skills/professionalism/timeliness/other _____)
was observed.

QI Project (Chapter 7) (each session) (Tab #VI)
[] QI staff evaluation review (Winter/Spring) [] not reviewed this session
[] Leadership self-survey (Fall) [] not reviewed this session
[] MATT Sim Evaluation (Spring, once) [] not reviewed this session
[] QI leadership direct observations (prn, while leading) [] not reviewed this session

Deficiencies identified?
_____
Action plans?
_____

Clinical Documentation (Chapter 8) (Fall Interns: H+P, DCSum; Fall seniors: Consults) (Tab #VII)
[] following documents reviewed with resident: (circle appropriate)
H+P Consult D/C Sum Clinic Note
[] Deficits noted:
_____
[] **Resident signed off this milestone**

Mini-CEX Feedback (Chapter 11) (each session) (Tab #VIII)
[] Issues with last Mini-CEX's reviewed, no significant problems identified
[] Issues with last Mini-CEX's reviewed, following problems/trends identified in:
communication organization med knowledge professionalism

Action plan from above deficiencies:_____

Evidence-Based Medicine Searches (Chapter 12) (each session; emphasize 3rd yr)
# of searches reviewed:_____
Depth of question
[] "surface" question one-dimensional or unanswerable
[] decent questions for literature search
[] deep, thought/study-provoking questions

Searching abilities
[]Rudimentary: Google level or only
[] comfortable with a few techniques
[]facile with multiple search strategies, strengths/ weaknesses of each Textword

Critical Incident/Audits of Care (Chapters 10, 13) (done on NF rotation)
[] None reviewed OR [] Reflections present? YES NO

Time management (Chapter 14) (optional)
[] not reviewed this session
OR Action plans _____
Ambulatory Portfolio (Chapter 16) (Winter, Spring session) (Tab #IX)

[] "my most meaningful patient" reflection (Jan) [] "the difficult patient" reflection (May)
[] Individual Practice Improvement Plan/ reflection (Jan) [] team meeting reflection (May, 1st/2nds)

[] **In-training exam** scores were reviewed. (**Winter, in binder; uploaded by resident**).(**Tab #X**)
(review uploaded reflections on scores in Chapter 17, incorporate into action plan)

ITE percentile: ____% Change from prior year:+ /-_____%

[] In-training exam scores excellent, no further feedback given

[] Deficiencies identified by in-training exam score, and the following actions were taken:

_____

If deficient, Board Review Attendance (in binder): ____ %

[] **Conference Attendance (each session) (Tab #XI)** _____%
Attendance to required conferences was discussed and was Satisfactory Unsatisfactory
(ABIM requires 60%; we recommend 70%)

[] **Procedure Lists** were reviewed **(each session; in binder) (Tab #XI)**
[] Resident was found to still need the following procedures (circle needed, slash thru done)
Required: ABG(5) Knee(5) Pelvic(5)
Other: Thora (5) Para(5) Cent: IJ (5) LP(5)

[] Online Module Completion (Tab #XI)
Completion of assigned IMP(or Berkshire Heights) cognitive exams: YES NO
Completion of assigned IPM Modules: YES NO
Duty Hours recorded (required for incentive) YES NO

Reflective capacity (all sections).

[] "Reporter". Demonstrates ability to engage in concrete experiences and record them. Patient care logs, Curriculum Vitae, records of learning complete with minimal effort made to reflect on contents. In critical incident writing, tells story concretely without identifying themselves or their emotions.

[] "Interpreter". Resident demonstrates abilities to perform above as well as the ability to reflect meaningfully on the experiences (scores, rotation evaluations, ancillary or peer reviews, critical incidents) and can say how they might have handled an individual situation differently. In critical incident writings, can identify their role, their emotions and the limitations their emotions added to the situation

[] "**Manager/Educator".** Resident shows ability to perform all of the above, and in addition is able to form an action plan for improvement as well as to apply the concepts to new situations In critical incidents, can not only identify emotions but can generalize in order to incorporate new behaviors and attitudes for future

TO-DO LIST for resident by next session (**Tab #I**):

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

MILESTONE REVIEW: Professionalism Interpersonal Communication Problem-Based Learning
Patient Care Systems-Based Practice Medical Knowledge

Appendix B –Morbidity and Mortality Conference

READING HOSPITAL
Department of Medicine

Purpose of Conference: Discuss an individual inpatient's medical course to learn from the patient case about improvement in quality of care and patient safety.

Theoretical Examples of Types of Appropriate Cases for M & M Conference:

- Appropriate pre-operative evaluation and peri-operative care for patients with sleep apnea or other diseases.
- Appropriate use of DVT of other preventive measures when patient is at risk.
- Judgment errors with limited differential diagnosis and inadequate diagnostic workup.
- Systems issues that may have led to or failed to detect an adverse outcome.

Objective of Resident Involvement: Develop experience in directing a patient safety and process improvement conference with specific educational end points.

Resident Role: The resident serves as the Director assigned to the Morbidity and Mortality Conference. The resident will work with the Junior Faculty Member and the Chair of the Department of Medicine. The resident's responsibilities include:

- Select a case that addresses the purpose.
- Plan speakers from the Medical Staff who are experts on topic.
- Plan and communicate the organization of the conference based on the focus of the patient event and teaching points.
- Generate greater understanding of medical topic based on literature search and discussion with conference speaker(s); also provide a reference article to the audience at conclusion.
- Clarify root cause issues contributing to the adverse outcome.
- Scholarly activity for resident in preparation of a conference, "teaching pearls" for resident to convey to conference attendees, potential for resident manuscript and publication as a case presentation, and scholarly activity for resident's CV.

Preparation Timeline for Department of Medicine M & M Conference

☐ Eight weeks prior to conference	Resident, Dr. Smith and Junior Faculty Member meet to identify case presentation and method of presentation. Resident reviews the medical record to develop case presentation.
☐ Seven weeks prior to conference	Resident meets with Dr. Smith and Junior Faculty Member to review the case presentation. Resident and Dr. Smith identify and invite the discussant.
☐ Six weeks prior to conference	Resident writes up case to share with discussant.
☐ Five weeks prior to conference	Resident discusses case with Dr. Neil Hoffman (Pathology) and Dr. Thomas Helinek (Radiology) or designate for the respective materials for the case presentation. Unknown case will be advertised in the Department of Medicine newsletter.
☐ Four – Two weeks prior to conference	Resident researches topic of case and meets with Dr. Smith and Junior Faculty Member to review the key points of the topic of the case and the lessons learned in the case presentation.
☐ Two weeks prior to conference	Resident confers with pathologist, radiologist, and discussant for any further information needed. Finalizes slide presentation with Dr. Smith and Junior Faculty Member.
☐ Two weeks prior to conference	Resident, Dr. Smith, and Junior Faculty Member coordinate with discussant, pathologist, and radiologist for presentation flow.
☐ One week prior to conference	Resident reviews for any last-minute preparation needs.
☐ Day of M & M conference conference.	Junior Faculty Member or Dr. Smith moderates the Resident initiates the conference with the case presentation. Resident ends the conference with a succinct teaching “pearl.”

Appendix C - Student Information for HTS

READING HOSPITAL
Department of Medicine

Student Responsibilities

- Third years carry two to three patients, while fourth years handle three to four.
- All students may write H&Ps and Progress Notes in the EMR using the student templates. Residents should give them feedback, but the Attending co-signs the notes.
- Students may write orders, which appear as saved work for you to modify or sign.
- Students take call with their intern Monday-Friday and one weekend day per month. Weekends are otherwise off.
- Students should be encouraged to join rounding on the rest of the service when their daily notes are completed, to expose them to more physical exam findings.
- Students should be encouraged to go with HTS patients to various studies and procedures (cath lab, GI lab, bronchoscopy, IR). Please help arrange this. Only students who have completed Surgery at Reading may go to the OR.

Student Evaluations

Please observe your students in action so you can coach them with daily feedback. They are here to learn!

When it comes time to complete an evaluation, your written comments about what they can and cannot do are very important in assigning a grade.

Attitude and reliability are important qualities of professionalism but do not in themselves determine the grade. Consistency in performing at a particular level is important.

You will hear the faculty describe students in the RIME framework. A summary is below:

- **Reporter:** Can work professionally with patients, staff, and colleagues, and accurately gather and clearly communicate the clinical facts on your patient and with the proper terminology. (This takes basic knowledge of what is important, plus the skill, reliability, and honesty to do it consistently.)
- **Interpreter:** At a basic level, you must identify and prioritize new problems as they arise. The next step is to offer a differential diagnosis. Success is offering more than one reasonable possibility for new problems and giving your reasons. (You won't always have the "right" answer.) This step takes growing knowledge, skill in selecting clinical facts, and seeing yourself as part of the intellectual process.
- **Manager:** This step takes even more knowledge and more confidence, plus the skill to select among options with your own patient; to be "proactive" rather than simply "reactive." Generally, your diagnostic plan should include more than one appropriate test option, and your therapeutic plan should consider the merits of all reasonable therapies. Always state your own preference. (You don't have to be correct.)
- **Educator:** Ultimately, your ability to help patients means an openness to new knowledge, and depends on your skill in identifying questions that can't be answered from textbooks. Are you able to site the evidence that new therapies and tests are worthwhile?

TRHMC Student Survey Responses

How you felt on the first day of your rotations: 1. Excited 2. Nervous/scared 3. Stupid/inept 4. Overwhelmed 5. Curious	Things you dislike on rotations: 1. Constantly moving to unfamiliar settings 2. Being tired (early/long days) 3. Feeling like opinion doesn't count 4. Feeling stupid 5. "Politics" – getting caught in conflicts of others
Most important factors to a good rotation: 1. Sense of teamwork 2. Attitude of residents 3. Enough responsibility/supervision 4. Good teaching 5. Organization/clear expectations	Favorite things about rotations: 1. Learning practical things 2. Procedures 3. Talking to patients 4. Being part of a team 5. Spending time with real doctors
Characteristics of your favorite resident: 1. Has patience 2. Enjoys teaching 3. Friendly/approachable/open 4. Gives useful feedback 5. Sense of humor/fun	Most memorable clinical experience: 1. Delivering a baby 2. Doing a procedure 3. Giving bad news 4. Participating in a code 5. Close relationship with a patient
Characteristics of least favorite resident: 1. Arbitrary/unclear or inconsistent expectations 2. Unhappy 3. Not interested in students/ teaching 4. Impatient 5. Unprofessional (to ward patients or colleagues)	Reasons for becoming a doctor: 1. To help people 2. Love of science 3. Like a challenge
Characteristics of a great teacher: 1. Enthusiastic about learning 2. Communicates well 3. Helps lead you to the answer 4. Patient 5. Encouraging	***Please notice that they DIDN'T say the best teachers are the smartest or the ones who send them off to read all the time – They love spending time with you!***

Appendix D – Clinic Process Information

READING HOSPITAL
Department of Medicine

(Information for TRH IMP nursing and secretarial staff)

Each June, there is a change of Hospital residents. An ongoing list is compiled of all patients of those residents who are leaving the program. The patients on the list are then divided equally among the incoming residents.

The out-going residents are asked to schedule as few patients as possible in July. In this way, each new resident's schedule is kept to a minimum until he/she is oriented to the Hospital. By block 2, most residents are able to assume a full schedule.

A patient is considered "new" for the following reasons:

- He/she has never been to TRH IMP or A4 before.
- He/she has not been seen for 3 full years.
- He/she has not been seen by the current resident assigned to this patient.

Traditionally, new patients are referred to Medical Clinic from the ED, HTS Service, private physicians, outside agencies, or individual requests for care. If the first available New Patient appointment is more than six weeks out, restrictions may be made to ED and inpatient referrals.

Resident Yearly Scheduling:

- In April, obtain the list of residents for the next year, including assigned clinic and team placement, from Dr. Nesfeder.
- Submit list to Gizelle Kremp, office manager of TRH IMP, with clinic start dates for all residents.
- Review scheduling template as follows:

  <u>First-Year Residents</u>
  - Start date through last week of July: one patient.
  - First week of August through June 23rd: three to four patients.

  <u>Second-Year Residents</u>
  - These residents will be assigned four follow-up patients and 1 acute slot.

  <u>Third-Year Residents</u>
  - The residents will be assigned four follow-up patients and 1 acute slot.
  - For these residents, no new patients after April 1.

APPENDIX E - RESIDENT SUPERVISION POLICY

READING HOSPITAL
Department of Medicine

Program Policy: **Resident Supervision** Effective: **February 2004**
Reviewed and Updated**: April 2016**

The Reading Hospital Department of Internal Medicine is committed to providing a learner-centered educational experience to our resident physicians. Services the residents provide should have some learning objective at all junctures, and should have the opportunity for supervision and backup whenever the need arises. Supervisors for the residents are on call 24-hours a day to support all resident activities, and to provide teaching, guidance, and support whenever and wherever necessary.

Residents are encouraged to alert staff with any care decisions they feel may be beyond the scope of their care, or to deal with any systems issues that arise during the course of their work.

Events for which residents will alert their direct supervisors include:

- Admissions to the Hospital
- Transfers to the ICU
- MATT calls on their patients
- Deaths on their service
- Medicine or other treatment errors or complications requiring clinical intervention
- Any significant change in patient condition, including an invasive procedure or operation

Residents will notify the HTS attending or the on-call faculty about patients meeting the above criteria. The house is also covered by hospitalists 24/7; issues at night that need a prompt answer and consultation (codes, AMA signouts) should be addressed to the covering hospitalist if an attending opinion is needed. In the case of non-service patients, interns or residents should notify the attending of record. The attending may request that the resident contact an existing consultant as well. If the primary attending wishes a new acute consultation, the attending may ask the resident to contact the consultant, but it is the responsibility of that primary attending to assure that the request is accepted in an expeditious manner.

Residents will review all admissions with a hospitalist, who will see the patient and provide an opinion. All patients not suitable for floor or PCU will receive a consult to the intensivist, who is also on call 24/7.

Information Available on the Intranet to Hospital Staff

Job descriptions for PGY1, 2, and 3 are available on the Hospital's intranet under Online Documentation as http://homen/residentcomp.htm. A list of procedures that individual residents are qualified to perform is also available at this site.

Appendix F – Scholarly Activity Policy

READING HOSPITAL
Department of Medicine

Institutional Policy: **Requirement for Scholarly Activity, Categorical Internal Medicine Residency**

Definitions:
Scholarly activity is broadly defined as follows:

- The Scholarship of Discovery encompasses those scholarly activities which extend the stock of human knowledge through the discovery or collection of new information. This includes basic or original research.

- The Scholarship of Integration encompasses scholarly activities which are primarily interdisciplinary or interpretive in nature. Such scholarship seeks to better understand existing knowledge by making connections across disciplines, illuminating data in a revealing manner, drawing together isolated factors, or placing known information into broader contexts. It synthesizes, interprets, and connects the findings in a way that brings new meaning to those facts.

- The Scholarship of Application encompasses scholarly activities which seek to relate the knowledge in one's field to the affairs of society. Such scholarship moves toward engagement with the community beyond academia in a variety of ways, such as by using social problems as the agenda for scholarly investigation, drawing upon existing knowledge for the purpose of crafting solutions to social problems, or making information or ideas accessible to the public.

- The Scholarship of Teaching encompasses scholarly activities which are directly related to pedagogical practices. Such scholarship seeks to improve the teaching and advising of students through discovery, evaluation, and transmission of information about the learning process.

Pursuing excellence in patient care requires a life-long commitment to learning by internists. During residency training, participating in the generation of new knowledge and dissemination of that knowledge are required by the Residency Review Committee for Internal Medicine. Your faculty's desire is to apply the above standards to support your life-long goals, in order to allow you to develop the career path that suits you best.

Resources for Research Assistance

All projects in early stages should be brought to the attention of your Mentor for development guidance or direction to a specific research Mentor.

Statistical support is available through the Department of Medicine on an as-needed basis. Contact the Program Director directly with your specific needs.

Research Rotations

Research rotations require preparation several months prior to the elective. Residents should meet with their mentors and clearly define goals of the research project, and complete adequate preparation that will allow adequate use of the research month. Research question and investigational method should be approved by the mentor and Program Director.

Appendix G – Clinical Hours Policy

READING HOSPITAL
Department of Medicine

Program Policy: **Clinical Hours** Effective: **January 5, 2004**
Reviewed and Updated: **May 2018**

The Internal Medicine Residency Program Clinical Hours Policy is as follows:

Policy:

- Residents will not be scheduled for more than 80 clinical hours per week, averaged over a four-week period,
- One 24-hour period in seven will be free of patient care responsibilities, averaged over a four-week period.
- Call frequency will be no more often than every third night, averaged over a four-week period.
- For upper years, there will be a 24-hour limit to on-call duty, with an added period of up to four hours for continuity and transfer of care, educational debriefing, and didactic activities; no new patients may be accepted after 24 hours.
- A 10-hour (12-hour for osteopathic interns) minimum rest between duty periods.
- In addition, the Program Director will assure adequate back-up support when patient care responsibilities are difficult and prolonged, and if unexpected needs create resident fatigue sufficient to jeopardize patient care.

Implementation:

It is Reading Hospital's responsibility to promote patient safety and education through clinical hour assignments and faculty availability. The institution will assure compliance to meet these needs in the following ways:

- Program Director, faculty, and residents will be educated to recognize the signs of fatigue and instructed in the effects of sleep loss and fatigue.
- Program Director and faculty will monitor resident assignments for those in which work-hour responsibilities or level of intensity are likely to produce sufficient resident fatigue to affect patient care or learning.
- Program Director will monitor moonlighting and other outside work for pay activities, which will be included in the work-hour calculations.
- The GME office will independently evaluate clinical hours. Resident Council members will be queried quarterly regarding rotations that may exceed the standards described above. Under the direction of the GME office, confidential time studies will be performed by residents on those services. Feedback will be provided to the Program Director, and follow-up actions will be requested.
- All residents will be required to sign an agreement supporting the Clinical Hours Policy.
- DME will report semi-annually (June and December) to GMEC on clinical hour compliance.
- An annual report will be provided by GMEC to the governing body on clinical hour compliance.

Appendix H – Moonlighting Policy

READING HOSPITAL
Graduate Medical Education

Institutional Policy: **"Moonlighting" and Other Outside Work for Pay** Effective: **May 20, 2002**
Reviewed and Updated: **May 2018**

Definitions:
Moonlighting is defined as work outside residency program duties that requires possession of a license without restriction or an interim limited license. Functions that are performed may replace those of another independent licensed practitioner in non-hospital locations.

Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.

Other outside work for pay is defined as non-curricular work that does not require possession of a physician license beyond the graduate-training license. An example of such work is performing history and physical examinations for an independent licensed practitioner who assumes supervisory responsibility.

Moonlighting and other outside work for pay are not required of any resident.

All moonlighting and other outside work for pay must be approved by the Program Director.
The following conditions must be met before "moonlighting" or other outside work is initiated by the resident.

- The resident must be in his/her second year of training or higher.
- The resident must be performing in a satisfactory manner in the residency program as defined by the Program Director.
- The sum of weekly resident duty hours and outside work hours should not exceed 80 hours per week.
- The resident must not have a J-1 Visa status, as such residents are prohibited by the Federal government from any form of moonlighting (Code of Federal Regulations – 22CFR 62.16).
- The outside work should be deemed of educational value by the Program Director. In addition, "moonlighting" requires a license without restriction or interim limited license in the state of Pennsylvania. (See http://www.pacode.com/secure/data/049/chapter17/s17.1.html)

Responsibilities:
Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with resident's fitness for work nor compromise patient safety.

The resident must notify the Program Director of his/her intent to work outside the program, the nature of the responsibilities, and the assurance that total hours worked in curricular and outside work activities do not exceed 80 hours per week.

The Program Director must authorize in writing that he/she is aware that the resident is involved in outside work activity, and provide appropriate documentation in the resident's file. A copy should be forwarded to the GME office.

The Program Director will monitor the performance of residents engaged in moonlighting/outside professional activities for the effect of these activities upon resident performance. Adverse effects of these activities upon performance may lead to withdrawal of permission.

The resident and Program Director should clarify liability coverage and obtain approval from Hospital Administration for any institution-related activities. Liability coverage for non-hospital related functions will be the responsibility of the resident and the institution hiring the resident.

Reading Hospital accepts no responsibility for resident malpractice coverage for outside work not involving the institution or its active staff.

A resident found to be in violation of this policy may face disciplinary action up to and including dismissal from the training program.

Appendix I – Request for Approval to Moonlight

Resident: _____

Department: _____

Definitions:
Moonlighting is defined as work outside residency program duties that requires possession of a license without restriction or an interim limited license. Functions that are performed may replace those of another independent licensed practitioner.

Other outside work for pay is defined as non-curricular work that does not require possession of a physician license beyond the graduate training license. An example of such work is performing history and physical examinations for an independent licensed practitioner, who assumes supervisory responsibility.

All moonlighting and other outside work for pay must be approved by the Program Director.
The following conditions must be met before "moonlighting" or other outside work is initiated by the resident.

_____ The resident must be in his/her second year of training or higher.

_____ The resident must be performing in a satisfactory manner in the residency program as defined by the Program Director.

_____ The sum of weekly resident duty hours and outside work hours should not exceed 80 hours per week.

_____ The resident must not have a J-1 Visa status, as such residents are prohibited by the Federal government from any form of moonlighting (Code of Federal Regulations – 22CFR 62.16).

_____ The outside work should be deemed of educational value by the Program Director.

_____ License without restriction or interim limited license in the state of Pennsylvania for moonlighting position only. (See www.pacode.com/secure/data/049/chapter17)

_____ The resident assures that the total hours worked in curricular and outside work activities do not exceed 80 hours.

_____ Adequate liability coverage is verified.

_____ The resident understands that liability coverage for non-hospital related function is the responsibility of the resident and the institution hiring the resident.

_____ The resident understands that Reading Hospital accepts no responsibility for resident malpractice coverage for outside work not involving the institution or its active staff.

_____ A completed copy of this form is provided to the central GME office.

Nature of outside employment responsibilities:

_____
_____
_____
_____

Please note: A resident found to be in violation of this policy may face disciplinary action up to and including dismissal from the training program.

Resident agrees to the above information:

_____
Resident Name (please print)

_____
Signature of Resident Date

Request for Approval to Moonlight approved:

_____
Program Director Date

Appendix J – Mini-CEX Rating Instrument

Reading Health System Minicard Rating Instrument -Pilot Date___/___/___

Student:_____ Observer:_____

Case description/Situation:

Directions: circle features done CORRECTLY, place "X" over ERRORS noted; add comments as necessar

History

Interpersonal/Communication skills

Greeting Set agenda, *"anything else?"* Uses open-ended , non-leading questior

1 Gives /responds to patient's non-verbal cues Uses summarizing/clarifying/reflective statemen

Demonstrates empathy *"that must have been upsetting"* Avoids medical jargon Attenti

Comments:

Data Collection: Applied Medical Knowledge

Elicits focused chief complaint General-to-specific questioning Got relevant PMH/SH

2 Asked discriminatory questions that prioritized differential

Comments:

Professional Conduct

3 Non-judgmental Does not make pt. "prove" illness Respectful to person/privacy/spiritualit

Comments:

Physical Exam

Physical diagnosis skills

Technically proficient at exam maneuvers Avoided irrelevant exam portions

4 Did not omit necessary elements of exam Used tools/positioning appropriately

Comments:

Medical reasoning/exam interpretation

Understood extenuating circumstances that limit exam's usefulness (e.g. steroids/peritonitis)

5 Understood general sensitivity and specificity of findings

Comments:

Professional Conduct

Asked permission/ explained exam Respects comfort/modesty Washes hands

6 Comments:

Assessment of findings

Oral case presentation
Could logically organize all relevant data Omitted irrelevant data
7 Incorporated pertinent pos/neg data Data given aids listener in assembling/ranking ddx
Comments:

Data synthesis/reasoning (applied medical knowledge components)
Logic, prioritization of differential is consistent, accurate Values datapoints appropriately
8 Analysis of prevalence of disease, test sensitivity/specificity obvious in discussion
Not reliant on single data point No omission of relevant data points that may refute diagnos
Recognizes knowledge gaps, formulates appropriate clinical questions Avoids early closure
Comments:

Plan: systems-based practice
9 Able to incorporate comorbid conditions into test/ treat. choices
Cost-conscious, ethical approach to testing Correctly identifies level of urgency of evaluation
Understands what to do with (pos/ neg) test results Uses ancillary staff/resources appropriately
Understands limitations of tests chosen (sens/spec/ risks of false pos results)
Comments:

Presentation of plan to patient/Counseling/Behavioral Change

Interpersonal/Communication Skills
Defines issue Shared decisionmaking *"Let's do this together"* Good pace
10 Common ground/patient education/understanding evaluated *"what do you understand about.."*
Avoids medical jargon Explores variables that would affect pt's choice
Pauses for/invites questions Respects pt. opinions and preferences Summarizes well
Gives and responds to patient's non-verbal cues
Comments:

Medical Knowledge components
Addresses uncertainties with choice (limitations of testing/therapy/varied patient response to tx)
11 Discussion of pros/cons of options (incl. nothing) Conveys risk in testing/treating
Demonstrates understanding of limitations in testing /treating
Comments:

Professionalism
12 Demonstrated no bias Not condescending Did not ignore pt's preferences Respectful

Total time observed____ Feedback given? Y / N

Next steps for this learner:_____

_____

Appendix K – Employer Survey

READING HOSPITAL
PO Box 16052
Reading, PA 19612

Dear Employer: Reading Hospital prides itself on training residents to adapt to new situations and challenges. We would greatly appreciate your input regarding your new graduate's performance in the following:

1. Team-building — not enough information to evaluate

MARGINAL	OK	GOOD	GREAT
Not a team player yet	Able to follow directions in a new system able to learn role on a team	Listens actively to all team members Has assumed a valuable role	has filled vital role to all members of team

2. Leadership Qualities — not enough information to evaluate

MARGINAL	OK	GOOD	GREAT
is still adjusting to our system	Can function well Within role; Respects others' roles	delegates responsibility effectively listens well	considers others' strengths when delegating leads without micromanaging

3. Adoption of new technology — not enough information to evaluate

MARGINAL	OK	GOOD	GREAT
Has not learned the technology we use here yet	has put great effort to learn our technology and "gets it"	adapted very quickly to our technology	is a "whiz" can teach others

4. Understanding Systems — not enough information to evaluate

MARGINAL	OK	GOOD	GREAT
Is not functioning as a full team member yet	understands our system and their role here	brings new ideas; can fully comprehend our process and compare	able to see weaknesses in our system and apply change, study its effects

Appendix L – Yearly Evaluation of Program

READING HOSPITAL
Graduate Medical Education

Modified: **March, 2005**
Reviewed and Updated: **April 2013**

Yearly program review provides an opportunity to assess the status of the program, define areas that need improvement, and establish an action plan for improvement. It serves as an important part of the continuous improvement process for medical education.

Attendees: At least three residents representing each year of training, the IM Program Director, and at least four key full-time and volunteer faculty

Time of review: Early June

Topics for Discussion:

- Internal review and RRC review citations; progress with outstanding issues
- Curriculum, with focus on the evolving competencies
- Duty hours and other quality-of-life issues
- Scholarly activity and involvement in QI education and implementation
- Summary of resident evaluations of program, faculty, rotations
- Outcome measures
- Review of graduate summaries and evaluations of graduates by current Program Director
- Summary of Mentor sessions
- Quality measures for resident, program, patients cared for by residents
- Perceived strengths of the program
- Perceived areas of need

Process:

- Program Director will provide review of above information.
- Each member of the team will provide his/her perception of strengths and areas needing improvement.
- A summary document will be created, describing effectiveness in achieving goals and objectives and listing specific suggestions for program improvement.
- Program Director will present this Yearly Program Review Document to the Clinical Competence Committee for discussion and approval. The document will include a specific action plan for program improvement. Follow-up will be planned through the Clinical Competence Committee. Progress and ongoing issues will also be discussed at the next yearly Program Evaluation meeting.

Appendix M – Resident Practice Improvement Plan Policy

Background: Current ACGME guidelines require all residents to demonstrate improved patient outcomes on their own panel of patients in the ambulatory setting in order to graduate. To enable residents to accomplish this goal, the residency program is required to generate a practice improvement plan for each resident based on their actual clinic data, and to meet with each resident at least twice per year to review their progress on achieving the goals set forth in the plan.

Policy

Each team leader will meet three times per year with each resident on their team. The purpose of the first meeting is to review with the resident the baseline data report on the patient outcomes that are being tracked for that academic year. These reports are generated by the residency program ambulatory training director and the outcomes chosen to be tracked each year are determined at the final ambulatory faculty meeting of the preceding academic year. The first meeting should occur in the October-November timeframe to review the 3-4 months of baseline data, and the faculty team leader and the resident will decide upon reasonable improvement expectations to be achieved by the end of the academic year. A written copy of this plan will be generated by the team faculty attending and then forwarded to the resident, resident's mentor, and the ambulatory training director by the end of the first week of December. The plan should be uploaded by the resident into their portfolio under the patient advocacy section, and the resident should place their reflections on their plan into this section, as well.

The second meeting will occur in the January-February timeframe, and is meant as an informal meeting in which the updated outcomes reports are reviewed with the resident by the faculty lead and further guidance or support is provided on the basis of the progress towards improvement goal. If all goals have already been accomplished, new goals can be implemented at this meeting. All updated plans are to be forwarded to the resident, resident's mentor, and the ambulatory training director by the end of the first week of March.

The third meeting will occur in the late April-early May timeframe, and is meant as the final status update on progress towards completion of the practice improvement plan. At this meeting, if the resident has failed to achieve their goals for the year, a remediation plan will be generated and the resident will be asked to reflect upon why they failed to achieve their goals. If the goals have been achieved, the resident will be asked to reflect upon what strategies they used to ensure success. A final report will be generated by the team faculty lead as to the status of the plan for an individual resident, and this report will be forwarded to the resident, resident's mentor, and the ambulatory training director by the end of the first week of June. This report will be uploaded by the resident into their portfolio under the patient advocacy section, and they will be asked to enter their reflections as stated above.

Example of a Basic Practice Improvement Plan

In meeting with the faculty lead for the Blue Team, patient outcomes data for 8 variables were reviewed today (see attached spreadsheet). Data for Dr. X compared to the rest of the Blue Team and the Clinic as a Whole were reviewed.

Issues of patient compliance are noted, however, there are possible EMR tools and physician behaviors that can help alleviate some of the issues.

By the end of January, 20xx, the following goals have been set for your care of your diabetic patients:

1) decrease the numbers of patients who have no glycohemoglobins in the system to 30% or less
2) increase the documentation of diabetic foot examinations to at least 50%
3) increase the documentation of pneumonia vaccination status to at least 50%
4) increase the documentation of smoking status on diabetic patients to at least 75%
5) increase the number of patients who have had nephropathy screening rate to at least 42%

Possible ways to achieve these goals include:

1) Reviewing the charts of your diabetic patients, identifying the patients who have not had their testing done and then calling/writing/otherwise contacting them to stress to them the importance of getting their testing done.
2) If you identify a financial/insurance/psychosocial issue that is a barrier to care, consulting Susan Randolph for assistance.
3) If the patient is refusing testing, to document refusal to test in the flowsheet ("refuses") so that something appears in that field and you get credit for the attempt. If the field remains blank, the null value will count against you in a pay-for-performance model.
4) Use the diabetes chronic care model form whenever possible, as it provides decision support and reminders regarding missing data.

Appendix N - Remediation Agreement

Residency Training Program
Tower Health
West Reading, Pennsylvania

A remediation agreement shall be completed for every resident being placed into a remediation program at Tower Health prior to each period of remediation. The arrangements described in this agreement are subject to Graduate Medical Education Policies regarding remediation, disciplinary action and adjudication of resident grievances, as detailed in the House Officer Manual. It is recommended that any resident placed on remediation have access to a mentor, who is not involved in the resident's direct evaluation and, if necessary, that appropriate counseling be arranged.

By signing this agreement (last page), the resident indicates that he/she understands the nature and structure of the remedial period. This does not in any way preclude the resident from pursuing an appeal of the decision for remediation based on Tower Health's Graduate Medical Education policy for the adjudication of resident grievances (see attached). An appeal must be submitted in writing to the Program Director, with copies to the Chair of the Department and the Chief Academic Officer.

Dr. _____ (the "resident"), a PGY___ resident in_____
at Tower Health requires remediation in _____
The dates of this remedial period will be from _____ to _____

This remedial period is required because of:

Failure to achieve a satisfactory level of competence during the original rotation on _____ (dates).

Consistent difficulties identified throughout residency training in the following areas: _____

Inadequate attention to, or, failure to maintain the standards of the profession as described in Tower Health's standards of ethical and professional behavior, including in particular the following points: _____

_____

The following specific weaknesses have been identified:

1. _____
2. _____
3. _____
4. _____
5. _____

REMEDIATION AGREEMENT FOR Dr. _____

I. Objectives of the Period of Remediation:

A. The Resident:
During the remedial period, the Resident agrees to:

1. Increase his/her reading in the area/s of _____, _____
_____
Paying particular attention to the following (Check all that apply.)
   - o basic science
   - o pathophysiology
   - o evidence based medicine
   - o clinical presentation
   - o management and approach
   - o therapeutics
   - o other: _____

2. Improve his/her clinical performance by:
_____
_____
_____

3. Improve the following behaviors during clinical rotations:
   - o Interactions with patients.
   - o Interactions with peers.
   - o Interactions with allied health professionals.
   - o Interactions with faculty and attending staff.
   - o Punctuality/accessibility/participation.
   - o Sense of responsibility.
   - o Other _____

4. Participate in examinations: (specify type, frequency)
_____
_____

5. Meet with Dr. _____(the "Remedial Supervisor") at _____ (specify daily, weekly, monthly) intervals during the remedial period to discuss progress and ongoing objectives.

6. Other: (specify)
_____
_____
_____

REMEDIATION AGREEMENT FOR Dr. _____

B. The Remedial Supervisor:

During the remedial period, the Remedial Supervisor agrees to:

1. Provide supervision to the Resident during the remedial period from _____ to _____.
2. Meet with the Resident weekly to review and discuss progress or lack thereof in attaining the objectives of the remedial rotation, and to keep records of these meetings, and to submit these weekly to the Resident's Program Director.
3. Help the Resident in achieving the objectives of remediation by: (check all that apply):
    - o Clarifying the difficulties the Resident is having in knowledge base.
    - o Providing extra teaching in clinical matters.
    - o Providing supervision and training in procedural skills.
    - o Counseling regarding attitudes.
    - o Directing the Resident to other specific sources of information on teaching.
    - o Assessing the Resident by means of _____
    - o Other: _____
4. Attest at the end of the remedial period whether the Resident has or has not met the objectives of the period of remediation.

II. Outcome of the Remediation:

Upon completion of the remediation period, one or more of the following outcomes may occur, as determined by the Residency Program Director, in consultation with the Clinical Competency Committee, depending on the Resident's performance: (check all applicable outcomes)

- o Reinstatement as a resident in the program with no loss of time or extension of training.
- o Reinstatement as a resident, with training extended as recommended by the Program Director and the Clinical Competency Committee based on time lost due to unsatisfactory performance.
- o An additional period of remediation.
- o Placed on probation.
- o Other (specify): _____

REMEDIATION AGREEMENT FOR Dr. _____

III. Signatures:

By signing this document, the Resident and the Remedial Supervisor indicate that they both understand the nature and structure of the remedial period, and their respective obligations. This does not in any way, preclude the Resident from pursuing an appeal of the decision for remediation, according to the Tower Health Graduate Medical Education policy (attached). An appeal must be submitted in writing to the Program Director, with copies to the Chairman of the Department and the Chief Academic Officer.

_____	_____
Signature of Resident	Date
_____	_____
Signature of Remedial Supervisor	Date
_____	_____
Signature of Program Director	Date
_____	_____
Signature of Chair of Department	Date

REMEDIATION AGREEMENT FOR Dr. _____

Final Outcome of Remediation
Residency Training Program
Reading Hospital

This form has been completed by the Program Director and has been ratified by the Clinical Competency Committee at its meeting of: _____ (date).
Dr. _____ (the "Resident") has completed a period of remediation in the area of _____ from _____ to _____

The final outcome of the period of remediation is as follows:

Specific Areas of Weakness	Resolved	Partially Resolved	Not Resolved

Specific objectives of the period of remediation	Exceeds Expectations	Fully Meets Expectations	Fails to Meet Expectations
1. Reading and demonstration of core knowledge			
2. Clinical performance			
3. Interactions with: a) patients			
b) peers			
c) Allied health professionals			
d) Attending staff			
e) others			
4. Punctuality			
5. Sense of responsibility			

6. Other: (specify)			

Final Outcome of Remediation for the Resident

New weakness identified since period of remediation began (if any):

1. _____
2. _____

Final Outcome of the period of remediation:

Overall, the period of remediation is considered: Successful Unsuccessful

The result of the remediation is:

Reinstatement as a resident in the program with no loss of time or extension of training.
Reinstatement as a resident, with training extended as recommended by the Program Director and the Residency Program Committee based on time lost due to unsatisfactory performance. The extended period of training will occur from _____ (date) to _____ (date).
An additional remedial period, from _____ (date) to _____ (date).
Placed on probation.
Other (specify): _____

Comments (by Program Director or Resident):

_____

_____

Signatures:

By signing this document, the Resident indicates that he/she has met with the Program Director to discuss the final outcome of the period of remediation and has reviewed this document. This does not in any way, preclude the Resident from pursuing an appeal of the decision for remediation based on Tower Health's Grievance Policy (see attached). An appeal must be submitted in writing to the Program Director, with copies to the Chairman of the Department and the Chief Academic Officer.

_____ _____
Signature of Resident Date

_____ _____
Signature of Remedial Supervisor Date

_____ _____
Signature of Program Director Date

_____ _____
Signature of Chair of Department Date

Appendix O – Probation Agreement

Residency Training Program
Tower Health
West Reading, Pennsylvania

A probation agreement shall be completed for every resident being placed into a probation program at Tower Health prior to each period of probation. The arrangements described in this agreement are subject to Graduate Medical Education Policies regarding remediation, disciplinary action and adjudication of resident grievances, as detailed in the Houseofficer Manual. It is recommended that any resident placed on probation have access to a mentor, who is not involved in the resident's direct evaluation and, if necessary, that appropriate counseling be arranged.

By signing this agreement (last page), the resident indicates that he/she understands the nature and structure of the probationary period. This does not in any way preclude the resident from pursuing an appeal of the decision for probation based on Tower Health's Graduate Medical Education policy for the adjudication of resident grievances. An appeal must be submitted in writing to the Program Director, with copies to the Chair of the Department and the Chief Academic Officer.

Dr. _____ (the "resident"), a PGY___ resident in_____
at Tower Health requires probation in _____. The dates of this probationary period will be from _____ to _____

This probationary period is required because of:

Failure to achieve a satisfactory level of competence during the original rotation on _____ (dates).

Consistent difficulties identified throughout residency training in the following areas: _____

Inadequate attention to, or, failure to maintain the standards of the profession as described in Tower Health's standards of ethical and professional behavior, including in particular the following points: _____

_____

The following specific weaknesses have been identified:

1. _____
2. _____
3. _____
4. _____

PROBATION AGREEMENT FOR Dr. _____

I. Objectives of the Period of Probation:

A. The Resident:
During the probationary period, the Resident agrees to:

5. Increase his/her reading in the area/s of _____, _____
_____
Paying particular attention to the following (Check all that apply.)
   - o basic science
   - o pathophysiology
   - o evidence based medicine
   - o clinical presentation
   - o management and approach
   - o therapeutics
   - o other: _____

6. Improve his/her clinical performance by:
_____
_____
_____

7. Improve the following behaviors during clinical rotations:
   - o Interactions with patients.
   - o Interactions with peers.
   - o Interactions with allied health professionals.
   - o Interactions with faculty and attending staff.
   - o Punctuality/accessibility/participation.
   - o Sense of responsibility.
   - o Other _____

8. Participate in examinations: (specify type, frequency)
_____
_____

9. Meet with Dr. _____(the "Probation Supervisor") at _____ (specify daily, weekly, monthly) intervals during the remedial period to discuss progress and ongoing objectives.

10. Other: (specify)
_____
_____
_____

PROBATION AGREEMENT FOR Dr. _____

B. The Probation Supervisor:

During the probationary period, the Remedial Supervisor agrees to:

11. Provide supervision to the Resident during the remedial period from _____ to _____.
12. Meet with the Resident twice monthly to review and discuss progress or lack thereof in attaining the objectives of the probationaryperiod, and to keep records of these meetings, and to submit these to the Resident's Program Director.
13. Help the Resident in achieving the objectives of probation by: (check all that apply):
    - o Clarifying the difficulties the Resident is having in knowledge base.
    - o Providing extra teaching in clinical matters.
    - o Providing supervision and training in procedural skills.
    - o Counseling regarding attitudes.
    - o Directing the Resident to other specific sources of information on teaching.
    - o Assessing the Resident by means of _____
    - o Other: _____
14. Attest at the end of the probationary period whether the Resident has or has not met the objectives of the period of probation.

II. Outcome of the Probation:

Upon completion of the probationary period, one or more of the following outcomes may occur, as determined by the Residency Program Director, in consultation with the Clinical Competency Committee, depending on the Resident's performance: (check all applicable outcomes)

- o Reinstatement as a resident in the program with no loss of time or extension of training.
- o Reinstatement as a resident, with training extended as recommended by the Program Director and the Clinical Competency Committee based on time lost due to unsatisfactory performance.
- o Other (specify): termination of resident's contract and discontinuation in the program, effective the end of the probationary period

PROBATION AGREEMENT FOR Dr. _____

III. Signatures:

By signing this document, the Resident and the Probation Supervisor indicate that they both understand the nature and structure of the probationary period, and their respective obligations. This does not in any way, preclude the Resident from pursuing an appeal of the decision for probation, according to the Tower Health Graduate Medical Education policy.

_____	_____
Signature of Resident	Date
_____	_____
Signature of Probation Supervisor	Date
_____	_____
Signature of Program Director	Date
_____	_____
Signature of Chair of Department	Date

Appendix P
International Clinical Experiences for Residents at Tower Health
Updated October 2014

Policy

Residents in training may wish to participate in an educational experience outside of the United States. This experience may offer the opportunity for the development of curricular competencies which would not be readily available during an experience at Tower Health or within the continental United States. In addition, residents and staff may wish to participate in clinical experiences that support populations who are medically underserved and in dire need of care.

1. International clinical experience is an elective component of the residency training curriculum, and Tower Health faculty member serves as supervisor
   LEVEL I (Curricular credit and continuation of all program benefits)
   a. Resident and Program Director should review the opportunity and establish the educational value of the experience. In addition, they should establish that there is not undue risk to the resident, relative to the value of the experience.
   b. A curriculum should be established.
   c. A letter of agreement should be created, using the standard format for away rotations. This agreement establishes the dates, nature of experience, supervisor, and financial arrangements including source of salary and malpractice during the experience.
   d. Malpractice coverage should be established – The resident may request coverage through Tower Health, but this will need to be approved by the Chief Executive Officer (see details below*). Alternatively, the program may offer malpractice coverage or waive any possibility of a malpractice suit. This should be outlined in the letter of agreement.
   e. Prior to signing the agreement, the plans for the experience should be reviewed with the Chief Academic Officer (CAO), and the experience should be approved by the Chief Executive Officer (CEO).
   f. Time away would routinely be considered a part of the resident's work experience. However, the resident must work with the program director to ensure that all other requirements of the program can be met.
   g. Prior to the rotation, the resident should review with Human Resources the benefits for personal health insurance when outside of country.
   h. Because this is part of the training experience and because the resident and staff are serving as representatives of Tower Health in providing "good will" efforts to those in need, workman's compensation would be extended to resident and staff during the work component of the international training experience.
   i. The resident will be required to purchase emergency evacuation insurance if not provided by the sponsoring agency (either by sponsoring agency or independent insurer) and provide proof of coverage prior to the trip.
   j. The trainee and program director will assure that any licensure requirements for the international site have been met. This information will be included in the agreement between the host site and Tower Health program.

2. International clinical experience is not a component of the residency training curriculum, but resident joins Tower Health faculty member on an international experience to provide medical care to an underserved population.
   LEVEL II (No curricular credit but continuation of all program benefits)
   Note that this option should rarely be considered in favor of option 1. Threshold for approval is very high.

   a. Resident and Program Director should review the opportunity and establish that the experience is appropriately supervised and does not create undue risk to the resident, relative to the value of the experience. Faculty member will provide a significant oversight role in the resident experience.
   b. Because a TH faculty is supervising the clinical experience, the resident may be able to claim educational experience (procedural skills and or clinical encounters), at the discretion of the Program Director and TH faculty.
   c. Malpractice coverage should be established – The resident may request coverage through TH, but this will need to be approved by the CEO (see details below*). Alternatively, the program may offer malpractice coverage or waive any possibility of a malpractice suit. This should be outlined in the letter of agreement.
   d. Plans for the experience should be reviewed with the CAO, and the experience should be approved by the CEO.
   e. Time away would routinely be taken from "PTO time" (vacation or IPA), although resident may use conference or other time not required to meet requirements of Tower Health, specialty board, or accrediting, at the discretion of the program director; if elective time is utilized, the program director must ensure that total work time and experience for the resident meets requirements by all appropriate accrediting bodies.
   f. Prior to the rotation, the resident should review with Human Resources the benefits for personal health insurance when outside of country.
   g. If not provided by the sponsoring agency, Tower Health will arrange insurance coverage for emergency evacuation#
   h. The trainee will assure that any licensure requirements for the international site have been met. This information will be established by the program director before requesting malpractice coverage from Tower Health.
   i. The resident will be required to purchase emergency evacuation insurance if not provided by the sponsoring agency (either by sponsoring agency or independent insurer) and provide proof of coverage prior to the trip#

3. International clinical experience is a component of the residency training curriculum, but the resident is not accompanied by a faculty member.
   Level III – Curricular credit and continuation of all program benefits; given absence of Tower Health *faculty, the resident and program director must meticulously defend the value of the rotation, credentials and reliability of the supervisor in assuring that curricular goals and objectives are met.*
   a. Resident and Program Director should review the opportunity and establish that the experience is appropriately supervised and does not create undue risk to the resident,

relative to the value of the experience. A clear rationale for the experience should include the import of the experience for the resident's future career goals and the limitations of experiences at Tower Health and in the continental United States.

b. A curriculum should be established.
c. A letter of agreement should be created, using the standard format for away rotations. This agreement establishes the dates, nature of experience, supervisor, and financial arrangements including source of salary and malpractice during the experience.
d. Malpractice coverage should be established – The resident may request coverage through Tower Health System, but this will need to be approved by the CEO (see details below*). Alternatively, the program may offer malpractice coverage or waive any possibility of a malpractice suit. This should be outlined in the letter of agreement.
e. Because this is part of the training experience, workman's compensation would routinely be extended to resident during the work component of their international training experience, but this must also be approved.
f. Plans for the experience should be reviewed with the CAO, and the experience should be approved by the CEO.
g. Time away would routinely be considered a part of the resident's training experience. However, the resident must work with the program director to ensure that all other requirements of the program can be met in the established residency timeframe.
h. Prior to the rotation, the resident should review with Human Resources the benefits for personal health insurance when outside of country.
i. The resident will be required to purchase emergency evacuation insurance if not provided by the sponsoring agency (either by sponsoring agency or independent insurer) and provide proof of coverage prior to the trip[#] (see below).
j. The trainee and program director will assure that any licensure requirements for the international site have been met. This information will be included in the agreement between the host site and Tower Health program.

4. <u>International clinical experience is not a component of the residency training curriculum, and the resident is not accompanied by a faculty member.</u>
LEVEL IV (No curricular credit and no institutional or program benefits)
   a. The experience is at the sole discretion of the resident and it should be clearly established that the experience is in no way related to the resident's relationship with Tower Health. The resident is strongly advised to review the risk/benefit of the experience with his/her mentor or program director.
   b. There will be no malpractice or workman's compensation coverage through Tower Health; if the resident believes that there are extenuating circumstances that would warrant such support, he/she should review with the program director and provide a formal request to the CAO and CEO.
   c. Time away will be assigned to "PTO time" (vacation or IPA).
   d. Prior to the rotation, the resident should review with Human Resources the benefits for personal health insurance when outside of country.
   e. It is advised that the resident carefully review any licensure requirements and support for emergent situations, which may be provided by the host organization.

*The Hospital is self-insured for malpractice. The program provides coverage of the volunteer activities if the professional services are rendered after first obtaining the prior written approval for coverage of the volunteer activities from the Chief Executive Officer of the Hospital or his designee. If volunteer activity is considered, approval of that activity (whether outside the United Stare or not) should be obtained in writing from the Hospital's Chief Executive Officer or designee.

#Residents may receive funding support for the emergency evacuation insurance through their Education Fund allotment. Cost is estimated to be approximately $3-4 per day. Example of an independent insurer: https://gallaghercharitable.ajg.com/.

Note that decision making for such elective rotations should be based solely on the learning goals of the resident and should not be impacted by program or faculty interests.

Appendix Q - Internal Medicine Clinical Competency Committee

Introduction

The Clinical Competency Committee is charged with: 1) reviewing all resident evaluations by all evaluators semi-annually; 2) preparing and assuring the reporting of Milestones evaluations of each resident semi-annually to the ACGME; and 3) making recommendations to the program director for resident progress, including promotion, remediation, probation, and dismissal. The Program Director is responsible for instituting an action plan for residents who are found to be performing below expectations.

Function

The CCC will meet twice monthly, reviewing a subgroup of residents at each meeting, with the resident's mentor present as the resident's advocate and collector of formative feedback to be returned to the resident. Additional meetings will occur as needed for the purposes of residents in remediation or probation. Milestones reporting meetings will occur at the semi-annual and annual program director / resident meeting.

Members will be appointed by the program director, and will consist of the internal medicine titled faculty (program directors, associate program directors, and clerkship director) as voting members with the chair being a voting member other than the internal medicine Program Director. Other faculty members will attend meetings to provide supplemental information to the committee but will be non-voting. Additionally, resident mentors will come to present their mentees' case for competence, but will abstain from voting on competence. Members of the committee who are also mentors are required to abstain from voting on competence their mentees.

Residents with academic difficulties will have a plan of action developed by the CCC who will forward their recommendations to the program director for implementation. Decisions regarding promotion, retention, and termination will be by majority vote of the committee. The program director will be charged with identifying residents who require special discussion by the CCC for potential adverse actions.

Summary of CCC review process

The voting members of the CCC will review all evaluations on a semiannual basis for a group of residents and will provide summary assessments and recommendations to the CCC. The committee can request additional information for problem areas, and consensus will be obtained for the final milestones reported for each resident. The CCC will then report their feedback to the resident's mentor. If a CCC member is the resident's mentor, they will assume the status of a non-voting member for the purposes of the discussion of that resident, to preserve their purely formative relationship.

Details of CCC review process

1. A voting member of the CCC will be assigned to review an individual resident's mentor binder and present the resident to the CCC (hereafter referred to as the second reviewer); the format of the presentation includes the resident's strengths, opportunities for improvement, and areas in which performance could not be determined from the material in the mentor binder.
2. The mentor of the resident serves as the role of the advocate for the resident, accentuating their strengths, clarifying performance in areas where the mentor binder material was not sufficient for a determination of performance, and defending any areas felt to be opportunities for improvement. A resident's mentor is not involved in the summative assessment of their mentee, even if they are normally a voting member of the CCC; this preserves their role as purely formative. It is understood that the mentor has access to the electronic portfolio, whereas the second reviewer does not, so there may be material of which the voting member is not aware that would assist the CCC in making performance determinations, in particular things that would place opportunities for improvement within a deeper context.
3. The CCC will then have further discussion based on the material presented by the second reviewer and the mentor, and will make their recommendations regarding summative assessment of performance to the PD, as well as formative assessment to the mentor of the resident, to allow for further counselling and growth of the resident.
4. The mentor will take the information provided by the committee, including areas of weakness or areas that need further information or observation, and will present that information to the resident for their action.

Results of CCC review process:

After the review of each resident, possible recommendations from the CCC to the PD are:

1. No problem exists, no action taken.
2. Non-reportable Actions – a problem exists and the resident should be informed and solutions suggested for the resident to begin a self-correction process. This is considered an early intervention before performance degrades to a level requiring reportable actions such as probation. If there are areas of multiple deficiencies, or one area of significant deficiency, but this does not yet reach a level of a reportable action, remediation will be recommended, and a remediation plan put in place per the remediation policies of the residency program. While failure to remediate may lead to repeating an academic year, this, in and of itself, does not necessarily equate to a reportable action.
3. Reportable Actions – a problem exists to the extent that adverse actions are required and the deficiency is such that future reporting to state medical boards, credentialing bodies, etc. is potentially warranted. This is reserved for major deviations from expected performance, whether or not it can be expected to improve to an acceptable level over time.

a. Probation – temporary (attending rotations with pay)
b. Suspension – temporary (not attending rotations, no pay), would require prolongation of time in program
c. Non-renewal of contract at the end of the year (requires 120 days' notice or as soon as that determination can be made)
d. Dismissal – permanent, no pay
e. Non-graduation (requires 120 days' notice or as soon as that determination can be made). Resident completes remaining contract term but does not receive final year credit or board eligibility.

As per institutional GME policy, all actions taken by the CCC are eligible for appeal through Academic Affairs.

CCC minutes will be kept on file by the program coordinator and be brought to the future CCC meetings for all to review as needed.

Appendix R - Definitions and Details for PTO/IPA/FMLA

Internal Medicine Residency Program

IM Residents don't accrue PTO & IPA as do traditional Tower Health employees, so the policy on the use of PTO and IPA differs from a traditional employee. IM Residents receive a lump sum at the beginning of every academic year because they are viewed as a yearly contracted employee. The traditional employee accrues/receives increments of PTO and IPA each pay period. See table below for explanation of how much time off is received for each year as a resident.

Year of residency	**PTO**	**IPA**	**Holiday Week (40 hours)**
1st	80 hours	96 hours	Yes
2nd	120 hours	96 hours + carry over from previous year	Yes
3rd	120 hours	96 hours + carry over from previous year	Yes

PTO – Paid Time Off

IPA – Income Protection Account (also known as sick time)

FMLA – Family and Medical Leave Act

PTO is to be used so you can be paid when you aren't at work.

IPA is to be used for when you are **personally** injured, ill and not able to work or for FMLA.

FMLA is job protection for your absence from work ***but not a guarantee of pay***. If leave is foreseeable, FMLA must be applied for 30 days before commencement of leave unless impractical to do so under the circumstances, in which case notice must be given as soon as possible. Being away from work for less than 7 working days, applying for FMLA is not required. An eligible employee is entitled up to 12 work weeks of FMLA job-protected leave per rolling, 12 month look back period.

Reading Health processes FMLA through a company called FMLA Source. It requires forms to be completed via website or telephone. It includes submitting a medical certification and a review by FMLA Source. After a decision is made for your leave dates, approval is sent to you and Dr. Cecilia Smith (Chair, Department of Medicine). Dr. Smith approves your time card. If you need to apply for FMLA, contact Tara Brown (x4441) for instructions.

Who can apply for FMLA (RHS Employee):

- Anyone who has completed at least 12 months of service and have worked 1,250 hours in previous 12 months.
- Anyone who is facing the following:
    - birth of a child
    - care for an injured service member
    - adoption or foster care
    - care for your own serious health condition
    - care for child, spouse or parent with serious health conditions

Common Uses for FMLA (there are more):

- Medical Leave
- Maternity Leave
- Qualifying Family/Parental Leave

While on FMLA:

The **IPA** time is used first. When the IPA time is exhausted, PTO will be used for the remainder of the time away.

Appendix S – Pay for Performance

Internal Medicine Residents
Pay for Performance Metrics for AY 2018-19

Semester 1 (payable in November): $500
Professionalism – $500 divided between two metrics:

1. Logs duty hours on required rotations within 1 week (HTS, NF, ICU) - $250 for 100% completion only.
2. Maintains an attendance at 80% or greater to conferences - $250 for 80% or greater, no payout if <80%.

Semester 2 (payable May): $1000

- Professionalism – $500 divided between two metrics:
  1. Logs duty hours on required rotations within 1 week (HTS, NF, ICU) - $250 for 100% completion only.
  2. Maintains an attendance at 80% or greater to conferences - $250 for 80% or greater, no payout for <80%.

- Scholarly Activity and Good Citizenship Reporting -- $500 maximum of approved options listed:

▪ Abstract (ACP Regional 1st or 2nd author or any author on any national level) ▪ Selection to teach session during orientation	$100/abstract $100/session
▪ PI on IRB Approved Study with Measurable Results plus Portfolio reflection entered	$200/project
▪ Publication	$300/publication
▪ Files an Adverse Drug Event Report to the FDA (must be sent to Dr. Donato with screenshot of report by May 15)	$100/filing max of 2 filings

Appendix T – Education Fund and CONCUR Reimbursement Protocol

INTERNAL MEDICINE RESIDENCY PROGRAM

Effective 6/18/2018

In order to support the educational mission of our resident physicians, RHTH has established an Education Fund to assist residents in covering costs for expenses incurred in support of their educational experiences. Purchases recognized by federal tax policy as tax-exempt income through a "fringe benefit" plan include:

1) Medical textbooks
2) Medical education software
3) Medical equipment – stethoscopes, etc.
4) Journal subscriptions
5) Membership dues (AMA, ACOG, PMS, etc)
6) Conferences – travel, hotel, registration, meals, etc.
7) Medical examination fees

PGY-1 Residents	
• Education Materials	$1,500 (not taxable)
• Pay for Performance maximum payout	$1,500 (taxable) - distributed December/June
TOTAL	$3,000
PGY-2 & PGY-3 Residents	
• Education Materials and Conference	$3,000 (not taxable)
• Pay for Performance maximum payout	$1,500 (taxable) - distributed December/June
TOTAL	$4,500

Any resident planning to attend a conference either by use of Education Fund or RHTH General Fund are required to submit Request to Attend email to Tammy Trace for upload to CONCUR. **Interns** are required to sign-on to this site and provide delegate access to Tammy Trace as follows:

1. Go to website: https://www.concursolutions.com
2. Sign in: username- firstname.lastname@towerhealth.org; password- welcome (you will instantly be required to change the password)
3. Once logged in, at the top RIGHT corner of the page click on PROFILE and then click PROFILE SETTINGS
4. On the LEFT side in the REQUEST SETTINGS section, click on Request Delegates
5. Click ADD, type TARA BROWN and check all boxes to the right of my name
6. SAVE

Upon return from conference detailed itemized receipts must be submitted to Tammy Trace for CONCUR submission and reimbursement within ten (10) days of conference end. No bank statements or credit card statements are accepted.

Likewise, receipts from education materials purchased by resident must be submitted to Tammy Trace for similar reimbursement.

Under no circumstances should residents submit to CONCUR on their own for reimbursement. Any resident found to have reimbursements over the totals listed above will be required to pay back the overage to RHTH.

Also, please note that any/all car rentals must be approved by Dr. Lloyd prior to submitting request to attend email.

INTERNS please complete delegate access request by **JULY 13, 2018**