IM Policy and Procedures Manual
Revised Version 6/24/2015
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PROGRAM POLICIES

1. INTERNAL MEDICINE RESIDENT PERFORMANCE STANDARDS

1.1 OBJECTIVE

All residents completing Internal Medicine Residency Training should have the clinical skills and overall medical competence necessary for certification of their clinical competence to the American Board of Internal medicine, should demonstrate moral and ethical behavior, and should have a reasonable expectation of passing the certifying examination of the American Board of Internal Medicine.

1.2 STANDARDS

A. SATISFACTORY RATING ON EVALUATIONS

Rationale

(1) The American Board will not admit residents with unsatisfactory evaluations to the qualifying examination.

(2) An unsatisfactory rating usually indicates significant performance problems.

Process

(1) Any unsatisfactory rating on ANY competency, on an end of the month rotation evaluation by a faculty member will send notification to the program director, who will review this with the resident and the faculty member. If the rating is correct, then corrective measures will be identified and instituted. Future evaluations will be critically reviewed to determine whether or not this problem has been corrected.

a. Decisions regarding circumstances such as placing a resident on notification, observation or probation from the program will be made by the Program Director, Associate Program Director(s), Clinical Competency Committee and the Chairman on a case by case basis.

B. CLINICAL SKILLS

Rationale

(1) Residents must demonstrate expertise in patient assessment, including thorough and well documented histories and physical examinations.
Process

(1) Each PGY 1 resident will have a MINIMUM of 6 direct observations, of various types, in this year. It is expected that the PGY 1 resident will approach faculty to accomplish these observations.* More is, of course, better. These direct observations may take place in the inpatient or outpatient setting.

(2) Each PGY 2 and 3 will have a MINIMUM of 4 direct observations, of various types, per year. It is expected that the upper level resident will approach faculty to accomplish these observations.* More is of course, better. These direct observations may take place in the inpatient or outpatient setting.

(3) The possible direct observation are as follows:
- Morning Report
- Counseling, Code Status, Family Meeting (senior resident)
- Counseling, Code Status, Family Meeting (interns)
- ECG/Chest X-Ray (senior resident)
- ECG Chest X-Ray (intern)
- Hand off (all PGY levels)
- Procedure (all PGY levels)
- History (all PGY levels)
- Physical Exam (all PGY levels)

(4) Resident documentation including histories, physical examinations, clinic notes, progress notes, and discharge summaries must steadily improve during the 3-year program and ultimately reflect high quality and thorough patient evaluation and assessment.

* The resident must ensure that the faculty is made aware of the observations that the resident expects them to observe and evaluate. The resident can do this by sending them an email or notifying them personally. However, the resident MUST email the coordinator to create the evaluation in the online software (Medtrics) or create it themselves.

C. PROCEDURAL SKILLS

Rationale

(1) The American Board of Internal Medicine requires documentation of procedures skills for clinical competence certification.

Process

(1) Residents must undergo training in procedural skills to be certified
as clinically competent to the American Board of Internal Medicine. This will include instruction and supervised practice.

(2) The resident will maintain and update an electronic logbook in the appropriate online software system (Medtrics).

D. ADVANCED CARDIAC LIFE SUPPORT

Rationale

(1) The American Board of Internal Medicine requires proficiency in basic life support, advanced cardiac life support, and cardiac defibrillation. ACLS certification documents competence in these areas.

Process

(1) Residents will maintain ACLS certification. Residents without such certification cannot be certified as clinically competent for the American Board of Internal Medicine.

(2) Residents without up-to-date certification will be removed from service. The department will pay for the initial ACLS course and one recertification during your residency.

E. EDUCATIONAL RESPONSIBILITIES

Rationale

(1) The American Board of Internal medicine requires each resident to have a significant fund of knowledge and to develop methods for maintaining this fund of knowledge. Internal medicine residency training implies participation in as many educational activities as possible. Participation in on-going departmental educational activities is expected.

Process

(1) Residents will attend at least 70% of conferences (after correction for vacation and special rotations).

(2) Residents who do not maintain a 70% attendance record every month will be assigned a topic by the Chief Residents/Program Leadership to present at the next available open noon resident conference.
(3) If the 70% attendance requirement is frequently not met, the Program Director will deal with this on a case by case basis.

(4) Residents are provided a listing of conference attendance requirements based on rotation at orientation and when revised. This listing determines the above mentioned attendance rule. The coordinator or administrative staff will not be excusing you from conference due to attending rounds etc. Therefore, you will need to make certain that you inform your attending that you must attend 70% of conferences.

F. MEDICAL RECORDS

Rationale

(1) The American Board of Internal medicine requires timely and legible records as one indicator of professional attitude and behavior. Proper records are essential for patient care.

Process

(1) Residents will maintain records, including all dictations, documentations and signatures, on a timely basis (up to 72 hours from encounter). Senior residents on teams will be responsible for ensuring the completion of the completion of medical records by junior residents.

(2) The expected response time for non-urgent clinic messages is within 72 hours. Urgent messages, and clinic pages, are expected to be the same day and ASAP. If someone is covering clinic, it is expected that clinic duties be completed as if the primary physician was present, with the exception of clinic box paperwork which may be attended to on a weekly basis.

(3) Attending physicians are ultimately responsible for record completion. If disciplinary action on an attending physician is due to resident delinquent documentation, the resident will be placed on observation. If the problem persists, the Program Director may choose to place the resident on Probation or Terminate on a case by case basis.

(4) Residents with persistent delinquencies may be placed on warning status or on probation depending on the nature of circumstances.

G. IN-TRAINING EXAMINATION
Rationale

(1) The in-training examination allows residents to identify areas of strengths and weaknesses and allows the resident to compare his/her overall performance with other residents at similar levels of training.

Process

(1) Categorical PGY I’s and all, PGY II, and PGY III residents will take the in-training examination during August - September of each year, excluding preliminary residents. No leave can be requested during the assigned dates. Once two dates have been selected within the ACP timeframe for the exam, program leadership will notify all residents.

(2) The Program Director or his/her designate will review ITE scores with all residents individually.

(3) PGY I residents below the 20th percentile will review their test results to identify areas of weakness. They must participate in a structured program of improvement in medical knowledge as outlined by the Program Director or their designee.

(4) PGY II and PGY III residents below the 30th percentile may have a serious deficiency in their fund of knowledge. These residents must participate in intensive and prolonged preparation for the American Board of Internal Medicine as directed by the Program Director or their designee. PGY III residents who score below this level should strongly consider a formal board review course.

(5) Residents with ITE below 30th percentile cannot moonlight. If the ITE results come in while the resident is moonlighting, they will be asked to notify the moonlighting supervisor to remove them from the moonlighting schedule.

H. ETHICAL AND MORAL BEHAVIOR

Rationale

(1) The ABIM expects all candidates to exhibit appropriate moral and ethical behavior in the clinical setting.

Process

(1) Each resident should demonstrate integrity, respect, and
compassion when providing medical care. These attitudes will be assessed by the residents’ action and behavior at work. Input will come from patients, nurses, other residents, and faculty.

(2) Residents are expected to demonstrate:
   a. Compassion, integrity, and respect for others
   b. Responsiveness to patients’ needs that supersedes self-interest
   c. Respect for patient privacy and autonomy
   d. Accountability to patient, society, and the profession
   e. Professional demeanor regarding attire should be consistent with the Department Policy.
   f. Inter-personal communication and work responsibility

(3) Residents with unacceptable behavior patterns will be placed on notification, observation, or if problems persist, probation. Some behaviors may be so unacceptable as to result in immediate termination or suspension from the program. This evaluation is admittedly subjective and will utilize all resources available to make proper decisions.

I. PROMOTION POLICIES

(1) The Internal Medicine Residency Program expects all residents who enter the program to satisfactorily finish the program with appropriate clinical skills, clinical knowledge, and professional attitude.

(2) Promotion Criteria for PGY-1 Residents:
   a. Completion of a minimum of 6, satisfactory direct observations. **Remember, it is the responsibility of the resident to notify faculty and to contact coordinator via email to create electronic evaluation or the resident create the evaluation themselves in Medtrics.**
   b. Review and approval by the Clinical Competency Committee. This committee meets monthly to assess resident progress. Unsatisfactory issues or evaluations that arise at these meetings can be taken into consideration for not promoting the resident, depending on the individual circumstances.

(3) Promotion Criteria for PGY-2 Residents:
   a. Completion of a minimum of 4, satisfactory direct observations. **Remember, it is the responsibility of the**
resident to notify faculty and to contact coordinator via email to create electronic evaluation or the resident create the evaluation themselves in Medtrics.

b. Evidence of satisfactory leadership during rotations on General Internal Medicine, CICU, and MICU. This is measured by peer evaluations and interprofessional evaluations.

c. Review and approval by the Clinical Competency Committee. Unsatisfactory issues or evaluations that arise at these meetings can be taken into consideration for not promoting the resident, depending on the individual circumstances.

J. GUIDELINES FOR RESIDENT SELECTION

Selection

Academic Ability
**Rationale:** Internist must acquire and utilize a complex fund of knowledge.

**Sources of Information:** Medical school transcripts, standardized test scores, letters of recommendation.

Clinical Skills
**Rationale:** Clinical skills represent the basis for all medical care in Internal Medicine.

**Sources of Information:** Letters of recommendation.

Professional and Interpersonal Skills
**Rationale:** Internist must have high quality professional and interpersonal skills.

**Sources of Information:** Personal statement, letters of recommendation, and personal interview.

Internist in Internal Medicine
**Rationale:** Training in Internal Medicine requires significant effort. Applicants with a high level interest are more likely to succeed.

**Sources of Information:** Personal statement, letters of recommendation, personal interview, prior training in Internal Medicine and related subspecialties (IMG Physicians).

2. RESIDENT OBSERVATION AND PROBATION

2.1 **OBSERVATION**

Rationale

(1) Resident may be placed on observation if their performance is deemed to be deficient in any of the core competencies.
The status of Observation will be determined by the Program Director, Associate Program Director, and members of the Clinical Competency Committee.

Residents placed on Observation will meet with the Program Director or his/her designee to discuss deficiency and areas of improvement.

A Letter of Deficiency will be given to the resident that will summarize facts, describe/define expectations and define actions of unsatisfactory performance.

A resident on Observation status that continues to show deficiency may be placed on probation. (See probation below).

### 2.2 PROBATION

**Rationale**

(1) Residents who are placed on probation have a serious performance problem and have a high likelihood of not being certified as clinically competent to the American Board of Internal Medicine.

**Process**

(1) Residents will be placed on a probationary period after they have received a written warning(s) and attempts at remediation regarding a deficiency in performance but fail to correct this deficiency. There may be circumstances where automatic probation (or termination) is warranted. These will be decided on a case by case basis and will include the Program Director, APD(s), Clinical Competency Committee and the Chairman.

Placement on probation will require a majority vote by the Clinical Competency Committee and approval by the Chairman of the Department of Internal Medicine. The decision to place a resident on probation CANNOT be appealed as per TTUHSC GME policies. At the time of probation, measures for corrections will be identified and instituted.

Follow-up evaluation and reassessment will occur over a specified period of time and will involve the Program Director and may involve the Associate Program Director, faculty or the Chief
Residents. The Clinical Competency Committee will review subsequent evaluations to determine whether or not the problem has been corrected.

(2) If deficiencies persist, the resident may be placed on continued probation (time determined by PD, APD, Post-graduate medical education committee) or terminated from the program. If terminated, the resident may make a direct appeal to the TTUHSC GME per their specific policies. Residents placed on a second probationary period may result in non-certification of their three-year training program. They may be asked to leave the program at the end of the contract year or they may be asked to extend their period of training for six to twelve months, depending on the deficiency and evidence for progress and improvement.

(3) Department policies are/will be consistent with institution policies. GME and institutional policies can be found at www.ttuhsc.edu/som/gme

(4) Internal Medicine Residency training requires significant and prolonged efforts to develop clinical skills and to master a large fund of medical knowledge. Outside activities such as moonlighting should not interfere with the residents' training responsibilities.

3. POLICY APPLICATION, DISSEMINATION AND REVISION

(1) The above policy applies to all residents in Internal medicine, including residents in preliminary positions and residents from other specialties rotating in Internal Medicine.

(2) This policy will be revised yearly by Program Leadership and Chief Residents, and distributed yearly among residents at the beginning of the academic year.

(3) The most current version of this policy shall be made available with easy access (online) to residents, faculty and administrative staff.
RULES AND REGULATIONS

1. PATIENT CARE RESPONSIBILITIES

1.1 PGY-I RESIDENTS

A. PGY - I residents are responsible for the admission, history and physical examination on each patient admitted to the teaching service. After reviewing the patient with the senior resident and the attending physician, if needed, PGY - I residents are responsible for entering the initial orders and for initiating diagnostic and therapeutic plans.

B. PGY - I residents with adequate supervision are responsible for performing all routine procedures on their patients. These procedures include arterial blood sampling, venous blood collection, nasogastric tube placement, thoracentesis, paracentesis, lumbar puncture, central vein cannulation, arterial cannulation, right heart catheter floatation, and bone marrow aspirate and biopsy. PGY - I residents should attend and assist with other procedures performed on their patient as time permits.

C. PGY - I residents are responsible for coordinating care provided by consultants, with the advice of senior residents and attending physicians.

D. PGY - I residents are responsible for reviewing pathological material and autopsies on their patients.

E. PGY - I residents will help coordinate discharge planning and providing patient education.

1.2 PGY-II, PGY-III

A. Senior residents (PGY - II and PGY - III) are responsible for supervising PGY - I residents throughout all aspects of each patient's in-hospital care, including history and physical examinations, diagnostic and therapeutic planning, and performing procedures.

B. Senior residents are responsible for developing a differential diagnosis and for reviewing therapeutic and /or diagnostic options early in each patient’s hospitalization.

C. Senior residents are responsible for coordinating work rounds and supervising medical students.

D. Senior residents are responsible for reviewing and providing clinical correlation needed for the interpretation of pathologic material.
1.3 ATTENDING PHYSICIANS

A. Attending physicians are responsible for informing senior level residents about each patient admitted by them to the teaching service and for providing an overview of diagnostic or therapeutic plans.

B. Attending physicians are responsible for supervising all aspects of patient care during each hospitalization and for leading teaching rounds.

1.4 CLINIC DUTIES

A. A pivotal part of the Internal Medicine program is the Continuity of Care Clinic and all activities and responsibilities related to this are equally important as inpatient service.

B. When resident have clinic scheduled it is their primary responsibility to be there on time and in the correct professional attire required by clinic (no scrubs).

C. All clinic EHR documentation related to a patient visit must be completed within 72 hours of the patient encountered and sent to the co-signing attending.

1.5 CLINICAL PICTURES

A. Residents and faculty should use the approved Departmental camera to obtain clinical pictures used for case presentations and scholarly activity. Contact Brandi McKinnon or Jade to access this device.

B. All clinical pictures should be performed after obtaining the appropriate verbal and written consent of the patient. Dr. Mulkey saves the pictures on a secure server and can email individual pictures when requested.

1.6 ACCESSING PATIENT INFORMATION

A. Residents should be aware that they may access patient information (opening patient’s medical record on the EHR) only when connected to direct patient care or scholarly activity. Residents should not open charts for non-professional matter and this constitutes a HIPAA violation which will be sanctioned. The hospital monitors constantly inadequate chart access.

2. PATIENT LOAD AND DISTRIBUTION

2.1 GENERAL GUIDELINES

A. Residents must balance the need for patient care, educational and their own needs for good mental and physical health. Patient loads will clearly depend on the
rotation, complexity and severity of the medical problems in hospitalized patients.

B. PGY - I residents should not have more than five admissions in any 24-hour period or eight admissions in any 48-hour period. After PGY - I residents have reached this level, the upper level resident should assume all admission responsibility for additional patients until the personal cap.

C. PGY - I residents should not continuously (no more than 4 days during a month) carry more than ten patients on any inpatient service.

D. Senior residents are primarily responsible for distributing patient among the team members. They should distribute in a manner that promotes efficiency and learning opportunities.

E. Senior residents should not have more than 10 admissions during a 24 hour period, and should not be responsible for more than 10 new patients and transfer patients in any 24 hour period (with the exception of night float).

F. Residents should not work more than eighty hours per week when averaged over four weeks.

G. Residents should have one day off every seven days when averaged over a 4 week period. The distribution of days off is the responsibility of the senior on the service. Conflicts arising from days off should be notified to Chief Residents.

2.2 IM FLOOR CALL AND CAP SYSTEM

A. All residents on the floor should follow the IM Floor Call system in accordance to the monthly schedule. The floor call system is a method to organize when teams are on call and how we distributed patients admitted to IM Floor.

B. Definitions
   Call Team: The team assigned to call that day. Call starts at 07:00 every day with checkout from the night float.
   Pre Call: The team who will have call the next day.
   Sister Call: The team who will have call in two days.
   Post Call: The team who had call the day before.
   Bounce back: A patient who was recently (within 30 days from discharge date) cared for in the hospital by a team.
   Bounce back (team specific): A bounce back to a specific team that occurs within the same calendar month. The importance of bounce back recognition resides in trying to obtain continuity of care for patients.
   Spot: The availability to assign a patient to a given team. Having “10 spots” means that team can obtain 10 patients in addition to the patient’s they may already have. A spot may be filled by a patient that has not yet arrived to the team, but is given that assigned spot. For example, when a direct admit is accepted from an outside facility,
that patient is given a spot on the receiving team. The number of spots available is
determined by the senior resident in conjunction with the attending following these
Policies.
Cap: The maximum amount of patients a team or resident can admit and carry. Cap
can be Team Cap or Personal Cap.
Team Cap: An IM floor team can have a maximum of 14 total patients, and a
maximum of 10 new patients in a 24 hour period.
Personal Cap: A senior resident may perform/supervise a maximum of 10 new
admissions (H&P) in a 24 hour period. A PGY-I resident may perform a maximum
of 5 admissions in 24 hours, or 8 admissions in 48 hours.

Assigned patients: A patient is said to be assigned to IM if the patient is
- Someone that sees one of our residents or faculty for primary care.
- Someone that sees another doctor for primary care (except Texas Tech
  family medicine) and sees one of our subspecialists for consultative care
  (all specialties).
- Someone that sees a private doctor for primary care but TTIM have
  admitted them to UMC and cared for them at least once in the past 2
  years.

Previously not assigned patients: Patients seen by Texas Tech family practice for
primary care (even if they see one of our subspecialists), any patient that is seen by
Physician Network Services (PNS) for primary care, any patient of Dr. Pirtle, Dr.
Hinshaw, Dr. Karkoutly or other physician having admitting privileges to UMC.

2.3 PATIENT ASSIGNMENT AND RESPONSIBILITY DURING CALL
A. It is important that during call, the person carrying the IM Floor Call pager (766-
9602) is aware of all the available spots for all the available team on call.

B. The senior resident carrying the IM Floor Call (Consults, On Call or covering senior)
is responsible for responding to other services requesting that a patient be accepted
to an IM medicine team.

C. If there is a question about accepting a patient to an IM Floor team, the resident
should contact the On Call attending to discuss the situation.

D. The assignment of patients to a specific IM Floor team is done using the following
diagram:
Patient requires admission to IM

Bounce Back (Team specific): Admit to specific team

Family Medicine or Private PCP? Hospitalist BB? Other service BB?

Not Capped

Not Holiday, Mon-Friday

Pre-call (1); up to 14

Sister-call (2); up to 14

Call Team (up to 14 total, up to 10 new admits; if 10 new admits limit reached, open 4 more when shift changes).

Capped

Holiday, Sat, Sun

Post Cap Admission Criteria: IM/IM Subspecialty Clinic Patient*, Bounce back to IM (not team specific), Mountford, State School, Unaccounted Direct Admit

Next day is M-F, Not Holiday

Next day Pre call (1); up to 14

Next day Sister call (2); up to 14

Hard Cap: Admit only Bounce Back, State School, Mountford, Direct Admit to Next day Call team up to 14.

Next day Sat, Sun, Holiday

Next day Pre call (1); up to 14

Next day Sister call (2); up to 14

Hard Cap: Admit only Bounce Back, State School, Mountford, Direct Admit to Next day Call team up to 14.
H. Patient assignments during call
   1. The MICU and CICU assignments are determined by their respective Team (senior, fellow and attending) and do not follow these guidelines.
   2. IM floor patient assignment
      i. The patient’s coming into IM Floor teams will usually be assigned in the following sequential order in order to progressively fill all the available spots: Pre Call, Sister Call and Call team. The resident coordinating patient assignments should try to assign patient’s so care is efficient and continuity of care maximized.
      ii. Pre call team will get 1 patient. The Pre call spot may not have a patient assigned after 13:30. If a patient is assigned after the Pre call team is finished rounds and there is a senior and/or attending available (not day off or in clinic), the Pre call team should perform admission. If the Pre call team is unable to perform a timely admission (within 1 hour), the patient should be admitted by the resident carrying the pager. The Pre call PGY-I may perform the admission with supervision of the covering/call resident.
      iii. Sister call team will get 2 patients. The Sister call spots may not have a patient assigned after 15:30. If a patient is assigned after the Sister call team is finished rounds and there is a senior and/or attending available (not day off or in clinic), the Pre call team should perform admission. If the Pre call team is unable to perform a timely admission (within 1 hour), the patient should be admitted by the resident carrying the pager. The Sister call PGY-I may perform the admission with supervision of the covering/call resident.
      iv. Next-Day’s Pre call and Sister call spots. There are situation where the day’s spots are reached but patient’s require admission. In this situation, the on call residents may admit Past Cap Admission to the next day’s Pre call and Sister Call spots.
      v. Past Cap admissions: Patients eligible for Past Cap admission are

Assigned patients:
   1. Patients that sees one of our residents or faculty for primary care. Patients that see another doctor for primary care (except Texas Tech family medicine) and sees one any of our subspecialists for consultative care (all specialties). Patient that see a private doctor for primary care but TTIM has admitted them to UMC and cared for them at least once in the past 2 years.
   2. Bounce backs (to internal medicine in general, or team specific).
   3. Montford patients
   4. Direct admits accepted by IM faculty
Lubbock supported living patients (State school)

2.4 **BACKUP SYSTEM**

A. When confronted with an unmanageable patient load, upper level residents should activate the backup system. The resident activating the back-up system should notify immediately the attending on call and the Chief Residents. The determination of the patient load as unmanageable is that the resident considers that patient safety is at risk.

B. The MICU/CCU resident should contact the fellow, on-call resident, or consult/night float resident when the patient load in the MICU/CCU becomes unmanageable.

C. The following residents will provide additional back up, in sequential order: Consults, Jeopardy, Chief Resident, and Faculty available for back-up.

2.5 **TRANSFER OF CARE**

2.5.1 **TRANSFER OF CARE AND CHECK OUT**

A. The objective of transfers of care is to provide timely and adequate information to ensure adequate patient care and safety.

B. Check out should be performed by residents in a face to face fashion using the following time frames:

<table>
<thead>
<tr>
<th></th>
<th>Regular day</th>
<th>Weekend/Holiday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AM Check out</td>
<td>PM Check out</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AM Check out</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PM Check out</td>
</tr>
<tr>
<td>Call senior</td>
<td>6:45</td>
<td>21:00</td>
</tr>
<tr>
<td>Call intern</td>
<td>6:45</td>
<td>19:30</td>
</tr>
<tr>
<td></td>
<td>6:45</td>
<td>6:45</td>
</tr>
<tr>
<td>Pre call</td>
<td>6:45</td>
<td>15:00</td>
</tr>
<tr>
<td>Sister call</td>
<td>6:45</td>
<td>15:30</td>
</tr>
<tr>
<td>Post call</td>
<td>6:45</td>
<td>15:15</td>
</tr>
<tr>
<td>MICU</td>
<td>6:45</td>
<td>19:00</td>
</tr>
<tr>
<td>CICU</td>
<td>6:45</td>
<td>17:00</td>
</tr>
<tr>
<td>Hem Onc</td>
<td>6:45</td>
<td>17:00</td>
</tr>
<tr>
<td>Consults</td>
<td>6:45</td>
<td>17:00</td>
</tr>
<tr>
<td>Jeopardy</td>
<td>6:45 Variable</td>
<td>NA</td>
</tr>
</tbody>
</table>

C. CICU residents work till 17:00 Mon-Fri and Weekends.

D. Consults, from Mon-Sat, will take pager at 6:45 until call team is finished rounding. If covering in the afternoon (weekdays only), they will give pager to on call resident after rounds and take again at 13:00 until 17:00 or when clinic is over, whichever is first. The consult resident should see all IM consults until 17:00 Mon-Sat. Consult
resident day off is Sunday
E. Neither the Floor on call resident nor the Consults residents have any MICU duties.

2.5.2 I-Pass Method
A. All residents are required to perform check out using the I-PASS method framework and the EHR tool.

B. The EHR tool (check out list) should be updated at least daily and should contain all I-PASS elements
   a. Illness severity
   b. Patient summary
   c. Action list
   d. Situation awareness and contingency
   e. Synthesis by receiver

3. DOCUMENTATION
A. PGY-1 residents with appropriate supervision should enter all the orders on all their patients. Every admission performed by a PGY-I should have supervision by either a

B. Senior residents should enter orders on their patients when PGY-1 residents are unavailable (for example, in Continuity of Care Clinic) or when the patient load prevents the PGY-1 residents for providing timely orders.

C. The attending faculty enter orders at their discretion and usually in the following circumstances:
   a. Urgent patient care considerations preclude the use of the usual line of responsibility.
   b. The pharmacy requires faculty signatures for certain classes of medication, such as chemotherapeutic agents.
   c. The faculty enters brief orders on clinic patients to initiate the admitting process.

D. All documentation related to a patient encounter should be completed in a timely fashion:
   a. All progress and consultation notes should be completed at least the same day of the patient encounter and in compliance with the supervising attending’s expressed expectation for the rotation.

E. All clinic EHR documentation related to a patient visit must be completed within 72 hours of the patient encountered and sent to the co-signing attending. It is expected that resident will adhere to the following guidelines when dictating/writing admission, progress and clinic documentation.
   a. HPI Elements: Location, Quality, Severity, Duration, Timing, Context, Modifying factors, associated signs and symptoms.

c. PE: 8 systems x 2 elements (inspection, auscultation, palpation, percussion) each.

d. Assessment and plan is a prioritized list of diagnoses/problems. Admission reason should be first one. Use descriptors of severity such as “severe, advances, unstable, worsening.”

**Inpatient Codes:**

Admit
99223 – 4 HPI, 10 ROS, 3 PFSH, 8x2 PE, High MDM

Follow up
99233 – No PFSH needed, 1-3 HPI, 2-9 ROS, 5x2 PE, High MDM

Consult
99255 – 4 HPI, 10 ROS, 3 PFSH, 8x2 PE, High MDM

Every note needs a plan of care for each problem/diagnosis. MDM medical decision making. X2 two of each system.

**Outpatient Codes:**

New patients/Consult
99203/99243 - 4 HPI, 2-9 ROS, 1 PFSH, 2-7x2 PE, Low MDM
99204/99244 - 4 HPI, 10 ROS, 3 PFSH, 8x2 PE, Moderate MDM, Attending must see patient
99205/99245 - 4 HPI, 10 ROS, 3 PFSH, 8x2 PE, High MDM, Attending must see patient

Follow-up
99213 – 1-3 HPI, 1 ROS, 0 PFSH, 2-7x2 PE, Low MDM
99214 - 4 HPI, 2-9 ROS, 1 PFSH, 2-7x2 PE, Moderate MDM, Attending must see patient
99215 - 4 HPI, 10 ROS, 3 PFSH, 8x2 PE, Moderate MDM, Attending must see patient

**4. NON-TEACHING PATIENTS**

A. Residents are not expected to provide physician services to non-teaching patients except in emergencies.

IM Policy and Procedures Manual
Revised Version 6/24/2015
5. INTERNATIONAL HEALTH ELECTIVE

A. International Health Elective: This rotation is not approved by the Internal Medicine Residency Program Director. For more information please visit the GME website for more information: www.ttuhsc.edu/som/gme

6. LEAVE AND COVERAGE RULES

6.1 GUIDELINES FOR REQUESTING LEAVE

Please review the requirements in this section carefully to avoid jeopardizing your training and needing to extend your training due to poor planning.

A. Up to one month (30 days including weekends) per academic year is permitted for time away from training, which includes vacation, sick leave, and maternity/paternity leave per the ABIM. Training must be extended to make up any absences exceeding 30 days 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. Therefore, only 20 days of working days are allowed to be requested before training is extended.

B. Residents in Internal Medicine will take their vacations on their elective rotations only. Residents are required to turn in a leave form in order to cancel clinics at least 30 days in advance. If 30 days’ notice is not given, your clinics will need to be covered by a peer (arranged by the resident with the covering resident not violating duty hours). If the resident does not submit a leave request form in the mandatory 30 day time frame, your leave could be denied.

C. Vacation will not be allowed on the following: Covenant, Neurology, Ambulatory, VA rotation, Geriatrics, MICU, General Medicine (Floor), General Medicine (Consults), CICU, Heme/Onc, Urgent Care, Jeopardy, or Emergency Medicine.

D. Any time a resident is leaving Lubbock for vacation, scholarly activity, interviews, exams, or personal reason, the proper leave should be submitted regardless of whether leave allowances are being used. Pager and clinic message coverage should be arranged as the leave form outlines.

E. If a leave request requires cross coverage, it is the resident’s responsibility to arrange the needed coverage without using Jeopardy resident. The Jeopardy resident will only be assigned to cover services by chief residents or program leadership only.

F. The resident requesting leave is solely responsible for arranging needed coverage, completing the leave and coverage form, and submitted. Subsequently, the chief residents, program director, and program coordinator will review the coverage plan for approval. If the resident is having difficulty arranging coverage they should seek the guidance of the chief residents and/or program coordinator.
G. Residents that will be performing coverage for absent resident should not agree to any coverage that will violate duty hours or impede their rotational or clinical duties.

6.2 **VACATION LEAVE ALLOWANCE**

A. PGY 1-3: 15 working days per year. Two weeks allowed to be used on one particular service at a time. Vacation leave time cannot be carried over from year to year.

6.3 **SICK LEAVE ALLOWANCE**

A. PGY I, II, III: 12 working days per year and can only be requested for illness or medical reasons.

B. The first (5) days of sick leave are paid and do not extend training. Subsequent sick leave may be requested, but will prolong training.

C. The resident may use an additional (7) days of paid sick leave, but any further leave will be considered “leave without pay.”

6.4 **MATERNITY/PATERNITY LEAVE**

A. Maternity/Paternity leave time must be used from the allotted vacation and sick allowances with the above mentioned parameters regarding paid leave, unpaid leave, and extensions of training. If additional time is needed, the resident can file FMLA. However, these additional days are unpaid and extend training.

6.5 **EDUCATIONAL LEAVE**

A. Educational leave used for USMLE exams, board review, interviews, and conference presentations does not count towards time away from program.

B. PGY-1 residents receive 3 days of Educational Leave, PGY-2 residents receive 5 days of Educational Leave, and PGY-3 residents receive 7 days of Educational Leave. Educational Leave cannot be carried over from year to year.

C. Residents will be allowed to use Educational Leave for the following:

   - essential examinations, such as Step III of the USMLE (test dates only), and only on electives
   - board reviews (only on electives)
   - conferences that resident is presenting for the time required to present only
   - fellowship interviews

D. Educational leave must be submitted on the proper (blue) leave form. If the leave is being requested to present research, the form must be submitted prior to submitting the abstract to allow the program and the resident adequate time to arrange coverage should the abstract be accepted. If the leave form is not turned in before abstract submission,
the program will not reimburse the resident for the abstract fee.

E. PGY 3 residents may use educational leave for both professional meetings and fellowship interviews. **Time required for interviews, board reviews, or scholarly activity beyond 7 days must be taken from vacation allowances.** Also, pay close attention to using your all of your leave time (educational, sick, and vacation) if **planning on taking vacation to move at the end of the year.** You must manage your educational days effectively. Please be responsible and make sure you have planned well.

### 6.6 DEPARTMENT SUPPORT FOR SCHOLARLY ACTIVITY

A. The Department of Internal Medicine will support resident travel to scientific meetings if the resident is making a presentation. **The department will support travel and conference expenses for the first scholarly presentation per resident each academic year.**

B. Institutional Travel Guidelines must be adhered to for airfare, hotel costs, and meal to be reimbursed.

C. If the department sponsors a resident for scholarly activity in which the resident receives a travel award, those funds must be returned to the department. Any money given to the resident as a scholarly award may be kept by the resident.

D. Expenses incurred in the meeting city outside of the meeting dates must be paid for by the resident. All travel must be approved in advance and the resident and the department should make an effort to limit costs. Unusual circumstances will be reviewed the Program Director and the Chairman.

### 7. PAGER USE AND COVERAGE

A. All residents are responsible to carry and maintain adequate functioning of personal and call pager. Running out of battery is not an excuse to miss answering pages. If a pager is malfunctioning, the resident should notify this immediately to assure pages will not be missed and pager may be replaced.

B. Residents are responsible for timely response to pages (ASAP).

C. When a resident is out of town, pager coverage should be arrange by that resident either by giving pager to a covering resident or leaving a pager greeting indicating how to contact that resident.

D. Text message pages may be sent online via [http://www.lrps.com/cgi-bin/pagepage](http://www.lrps.com/cgi-bin/pagepage)
E. The pager message may be changed as following:

**Pager Message Instructions**
1. Phone your pager number
2. During the greeting press (0)
3. Enter your access code (last four digits of pager number)
   a. Record Greeting Message
      - Press (30) to start recording
      - Press (1) to stop recording
      - Press (40) to playback your message

F. Floating pagers: The Following on call pagers will be transferred from resident to resident for call.

- Intern floor call pager: 721-4950
- Senior floor call pager/IM Consult pager: 766-9602
- MICU Intern: 721-2000
- MICU Senior: 721-0273

8. **CLINICAL ROTATIONS WITH MEANINGFUL RESPONSIBILITY**

A. Certification by The American Board of Internal Medicine requires 36 months of training in Internal Medicine. 24 months must involve "meaningful" patient care responsibilities. This means that the resident is directly involved in patient care, including the initial assessment, daily progress notes, order writing, test scheduling and interpretation, and management. In our departments the following rotations qualify as meaningful patient care months:

- ER
- Covenant
- General internal medicine floor rotation
- MICU/CICU rotation
- VA outpatient clinic rotation
- General medicine consults rotation
- Urgent Care clinic rotation
- Hematology-Oncology inpatient rotation
- Ambulatory rotation

B. In general, subspecialty rotations do not count toward months of meaningful patient responsibility as the resident primarily provides advice to the primary care team.
9. **PROCEDURE LOGS**

A. All residents should record every procedure whether directly performed and when
supervising junior residents, in Medtrics.

B. Only procedures recorded in Medtrics will be counted towards your procedure
numbers by the program.

10. **INTERNAL MEDICINE RESIDENT BENEFITS**

**1st YEAR RESIDENTS:** Current MKSAP (or book of choice by program director).

**2nd YEAR RESIDENTS:** $400 allowance for *travel, books, subscriptions. Remaining
amount can be carried forward to 3rd year if not used in 2nd year.

**3rd YEAR RESIDENTS:** $600 allowance for *travel, board review courses, ABIM
examination fee. All remaining funds must be used before June 30th of your third year.
Any funds carried forward from PGY II year must be used by this date also. If funds are
not used by June 30, we cannot process paperwork.

**ACLS COURSE:** Paid for by the department, whether recertification or initial
certification if course is taken at TTUHSC.

**LAB COATS:** 3 coats per PGY I residents, thereafter replaced on an **as needed** basis.
Coats will not be replaced unless they are worn out. Cost per coat: $47.00

**MEALS:** Meal cards will be provided for all Internal Medicine Residents for $95.00
per month for PGY-1’s and $75.00 per month for PGY-2’s and 3’s. Previous monthly
balances do not carry forward to the upcoming month.

**PRINTING SERVICES:** Residents who are presenting scholarly activity can request
printing services for their posters. The request should be made 2 weeks prior. The
resident must email the poster in proper format and size to Brandi McKinnon. A sample
poster is provided in drop box. Posters will not be laminated.

**TRAVEL STIPEND:** Will be provided for educational and scientific meetings at
which the resident is presenting. You must notify the Residency Coordinator for
approval by Program Director. The resident is responsible for making travel
arrangements and will be reimbursed upon providing receipts. You will turn in receipts
at the end of trip and must be done within 30 days from date of the conference.

**ABSTRACT FEES:** The program will reimburse the resident for accepted
abstracts/poster presentations fee provided the reimbursement documentation is turned
(including blue educational leave form). If the receipt for the abstract is not submitted
within 60 days after payment, the department will not reimburse.
11. RESIDENCY ROTATIONS AND SCHEDULING

PGY I
General Medicine  3 months
MICU  3 months
CICU  1 month
Hem/Onc In-Patient  1 month
ER  1 month
Electives  3 months

PGY II
General Medicine  3 months
MICU  1 month
CICU  1 month
Hem-Onc In-Patient  1 month
Consults  2 month
VA Clinic  1 month
Ambulatory Block  1 month
Electives  2 months

PGY III
General Medicine  1 month
MICU  1 month
Neurology  1 month
VA Clinic  1 month
Urgent Care  1 month
Geriatrics  1 month
Jeopardy  1 month
Covenant  1 month
Electives  4 months

Available Electives: Allergy, Endocrinology, Hematology/Oncology Consultative Service, SW Cancer Center, Infectious Disease, Rheumatology, Research, Pulmonary Procedures, Electrophysiology, and Heart Station. Other electives desired will be considered on a case by case basis.

Final schedules will depend on multiple intra and extra-departmental factors.

The monthly scheduling is performed in advance and is made based on consideration of educational objectives for each rotation, duty hours and optimizing efficiency and patient safety. Not all resident will have the equal number of days on every rotation (i.e. Night float). The switch days for days/night are chosen to allow the smoothest transition possible and not incur in duty hour violations or excess of cross coverage.

12. CONFERENCE and SCHOLARY ACTIVITY
A. All residents are required to attend conference on a routine and timely manner.
B. Resident should manifest to attending and fellows their conference schedule to allow timely coordination of clinical duties to coincide with conference attendance.

C. Some clinical rotation do not allow for conference attendance on a regular basis and the excused conference list is as follows:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Excused Conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>None</td>
</tr>
<tr>
<td>Cardiology</td>
<td>All AM Conferences (must sign in to cardiology conference)</td>
</tr>
<tr>
<td>CICU</td>
<td>All AM Conferences</td>
</tr>
<tr>
<td>Covenant</td>
<td>All AM Conferences</td>
</tr>
<tr>
<td>Dermatology</td>
<td>None</td>
</tr>
<tr>
<td>ER</td>
<td>Conferences while on nights only</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>None</td>
</tr>
<tr>
<td>GI</td>
<td>None</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>None</td>
</tr>
<tr>
<td>Consult/NF</td>
<td>While on Nights only</td>
</tr>
<tr>
<td>Endo</td>
<td>None</td>
</tr>
<tr>
<td>Floor</td>
<td>None</td>
</tr>
<tr>
<td>Hem/Onc</td>
<td>None</td>
</tr>
<tr>
<td>ID</td>
<td>Monday Noon Conferences (need to sign in to Ipad under IM)</td>
</tr>
<tr>
<td>Pulm</td>
<td>Monday Noon Conferences</td>
</tr>
<tr>
<td>Research</td>
<td>None</td>
</tr>
<tr>
<td>MICU</td>
<td>All AM Conferences</td>
</tr>
<tr>
<td>Neph</td>
<td>None</td>
</tr>
<tr>
<td>Neurology</td>
<td>None</td>
</tr>
<tr>
<td>Other Electives</td>
<td>None</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>None</td>
</tr>
<tr>
<td>Jeopardy</td>
<td>None</td>
</tr>
<tr>
<td>VA</td>
<td>All AM Conferences</td>
</tr>
</tbody>
</table>

D. Residents cannot take leave on IM In-training Examination dates. Residents cannot take leave while on Floor, ER, MICU, and CICU in order to take Step 3. Residents must make arrangements for this exam on Elective months.

E. All residents are responsible for timely Medtrics input for the following:
   - Duty hours due the 3rd day of each month.
   - All scholarly activity (Publications, Morning Reports, Journal clubs). In addition, the Powerpoint presentations used must be sent to Assistant Program coordinator for uploading (Jade) the day of the presentation.
   - Peer, faculty, and medical student evaluations.

F. All resident must read and participate in the Clinic Conference article discussions each month. It is the responsibility of each resident to check Dropbox to obtain the
article at least week in advance. These are generally the second week of the month, but some exceptions occur due to holidays etc.

G. Morning Report or Journal Club are assigned based on rotation and are expected to be presented on the assigned date given by the chief residents. In unusual circumstance that the resident in not able to present, the chief residents should be notified ASAP. The resident assigned is primarily responsible for this activity.

H. Yearly, a practice audit is performed and specific instructions are sent out to each resident by the Program Director. Timely completion of this is mandatory and it should be turned into either the Program Coordinator or Program Director.

13. MOONLIGHTING

Internal Medicine Residency training requires significant and prolonged efforts to develop clinical skills and to master a large fund of medical knowledge. Outside activities such as moonlighting should not interfere with the residents' training responsibilities. The Department of Internal medicine has the following guidelines for moonlighting:

A. Residents in the PGY I year, regardless of prior clinical experience or prior training, will not moonlight.

B. Resident on J-1 visas are not allowed to moonlight. All other residents can moonlight internally only. Internal moonlighting is allowed as long as it does not interfere with the ability of the resident to achieve the goals and objectives of the educational rotation and the total working hours do not exceed the ACGME 80 hours per week (averaged) limit.

C. Upper level residents on either General Medicine floor services, MICU/CCU, Hem/Onc or Consult/Night Float services will not moonlight during these rotations.

D. All residents will request and receive Program Director written approval for moonlighting and complete any necessary documentation.

E. Each resident must log their moonlighting hours (daily log of hours worked) that is submitted with regular duty hours by the end of day on the 3rd of each month.

F. Any irregular reporting (whether intentional or unintentional) will result in immediate suspension of moonlighting and could possibly result in probation. Repeated attempts of under reporting or failure to report may lead to expulsion from the program.

G. Any resident whose performance has been adversely impacted by his/her moonlighting activities will be temporarily suspended from moonlighting until significant improvement of his/her performance is demonstrated. Failure to comply with the request along with continued suboptimal performance may result in
suspension, delay in completion of training, or expulsion from the program.

Note: The aforementioned performance standards and other policies not all inclusive. Performance problems not covered by these guidelines will be addressed by the program Director and the Clinical Competency Committee on an individual basis.

14. MISCELLANEOUS

A. Usually most day to day resident inquiries may be resolved verbally. If a formal requests, complaint, suggestion and questions needs to be addressed, the resident should contact Chief Residents preferably via email (ttuimchief@gmail.com)

B. Resident must notify change of address immediately to GME and Program Coordinator. Also, residents must be aware that changes of address notification are required for insurance, visa, OASIS, Homeland security, TMA, etc. and this is personal responsibility.

C. Resident should keep their boxes clean to allow mail delivery.

15. UNFORSEEN EVENTS

A. Any resident that is not able, for any reason, to fulfill their clinical or academic duties should notify the Chief Residents and the Program Coordinator immediately. Notification should include the clinical duties that the resident will not be able to perform (service, clinics, conference presentations, pager, clinic inbox messages) and an estimate of the time of absence.

B. Leave time for unforeseen events must be requested via a leave form ASAP and coverage determined in the appropriate space on the form.

C. If there is a circumstance or situation that is not covered in this document, the resident should contact the chief residents for guidance.
SERVICE OUTLINE SENIORS

1. Senior Floor Service

1.1 Weekdays

- Day begins at 06:45 am sharp with AM checkout.
- Go to morning conference. Conference starts at 0800.
- Target to be ready to round with team between 9:00 – 9:30 am. Coordinate this time with the attending and rest of team.
- Finish rounding and pending discharges by 12:00 pm
- Go to noon conference
- You may need to pick up pagers in afternoon even when your team is not on call based on flow sheet, depending on which residents are in clinic or are off. Do not try to schedule your day off on these days.
- You may need to assist other IM services if special situations arise.
- Ensure patients are stable and receiving appropriate care.
- Make sure checkout is completed (you may hand over consults at 20:45 and afterwards to night float team)
- Check out with your attending before you leave for the day.
- If you are on sister call, you may receive up to two patients before 3:30 pm.
- If you are on precall, you may receive one patient before 1:30 pm.
- If you are requesting a consult from another IM service that is overloaded, do the consult H&P for the service.
- Coordinate days off between yourself and the intern. There will be some days off scheduled for the intern when switching between day and night float, you may not take off on these days.
- Do not take off on the day the intern switches.

1.2 Call

- Pick up IM consult pager after morning rounds or at 12:00 pm, whichever is earlier.
- If IM consult is requested by Ortho, etc, notify consult senior up to 5pm. If consult senior is in clinic, the new consult is your responsibility, triage appropriately. You may refuse consults from other resident services that are not in a doctor to doctor fashion.
- Admit patients in ER, place admission orders quickly as we are timed and update the ER physician as to the plan
- You may discharge patients from the ER. This may only happen after discussion with your attending; these patients do not count to your cap.
- Cap at 10 new patients or 14 max patients, bounce backs can count toward your cap if you have less than 14 patients but you must take them even if it causes you to overcap.
- If your team is capped and you are called to admit an IM clinic patient these patients may be admitted to pre-call and sister-call for the next day. Notify precall / sister call teams they you will be filling tomorrow’s slots for them, if
they are still in the hospital they should do their own admission.
• Notify Triage attending and floor attending when capped.
• Each intern can be responsible of up to 5 new admissions and 2 in-hospital transfers.
• Montford and State School patients must be admitted by our service. If sister and pre-call are filled then admit to the next call team. Even on weekends.

1.3 Call after hours
• From 17:00 pm until 21:00, will need to cover all IM consultations
• The HUC should call the fellow with consults and then the fellows will contact you for the consult if it is urgent
• You will be responsible for Hem/Onc admissions as needed. You will be covering BMT unit as well
• If reasonable, present patients to respective consultants
• Give consult pager to night float resident at 20:45, along with checkout of consultations done and items pending
• You may hand over consults at 20:45 and afterwards to night float team to allow sufficient check out time.
• Answer clinic calls and triage patients responsibly. Document all calls by sending a message to the primary care provider through powerchart.

1.4 Call on Weekends / Holidays:
• Triage all problems, coordinate procedures, and answer clinic calls.
• If your team is on-call Saturday, you will have to stay overnight and leave the next morning by 11am. Do not schedule your intern to be off on these days.

2. MICU Senior Service

2.1 Weekdays Day Service
• Shifts are 12 hours + check out time (06:45-1900), arrive early as you will be relieving night ICU senior
• Pick up ICU and code pager when your shift begins. (You may not leave the hospital while carrying code pager)
• Review morning labs, and prepare for morning rounds
• Know all patients.
• Admit ER patients to ICU as appropriate (you may take the intern with you to the ER to help out with the H&P and orders).
• Supervise hand-off of patients between services and coordinate transfers. Notify the consult senior of patients that will be transferred to floor teams
• Supervise procedures.
• Allocate work appropriately between interns
• There is no cap on the ICU service.
• If you are called to a code, arrive promptly. If you are called to another code while running the first code, call your associate senior or intern to assist in running the other code.
• You will hand off pagers along with appropriate check-out from 18:45-19:00.
2.2 **Weekdays Night Service**
- Shift is 12 hours (18:45-07:00)
- Know all patients
- Supervise procedures
- Admit ER patients to ICU as appropriate you may take the intern with you down to the ER to help out.
- Allocate work appropriately between interns, in coordination with day senior.
- If you are called to a code, arrive promptly. If you are called to another code while running the first code, call your associate senior or intern to assist in running the other codes.
- You will hand off pagers with appropriate check-out starting at 0645 am.

2.3 **Weekend and Holidays Day Service**
- You will get one day off per week, Wednesday. You are allowed to leave at noon on Friday
- Arrive at 06:45 am on Saturday and Sunday to assume care of patients.

2.4 **Weekend Night Service**
- You will get one day off per week, Friday night.
- Arrive at 20:45 on Saturday and Sunday to pick up pager from the day senior.
- Hand off ICU / code pagers at 06:45.

2.5 **Switching Between Nights to Days**
- On your day of switch, you will stay until 12:00 pm the next day and hand off pagers according to flow sheet.
- You will be given ~18 hours off to rest before resuming clinical duties at 06:45 am the following day.

2.6 **Switching Between Days and Nights**
- You will finish clinical duties the evening before at 19:00 based on rotating schedule.
- You will resume clinical duties after ~24 hour rest at 18:45 based on rotating schedule.

3. **IM Consult Service**

3.1 **Weekday Day Service**
- Arrange at 0645 am and pick up IM consult pager
- Notify appropriate services of new admissions / consultations if not already done.
- You will be responsible for new admissions from the ER while carrying the IM consult pager. If the sister call or precall team is finished rounding and has a spot open then that new admission will be their responsibility.
- You will be responsible to round on patients from IM consult services (usually post op patients from Orthopedics)
- Notify triage attending when various call teams slots are filled.
- Coordinate MICU and CICU transfers and notify teams of their assignments
• You will be responsible for new IM consults from 0700 until 1700.
• In the afternoons, you may be called to cover floor / ICU pagers as needed based on flow diagram.

3.2 Weekday Night Service
• At 20:45 you will pick up IM Consult pagers.
• You will be covering floor admissions, heme/Onc admissions, IM consultations, clinic calls and BMT questions for the night.
• If capped and called to admit IM clinic patient, State school, and Montford patients, admit patients to precall and sister call teams and notify appropriate teams in AM at check out.
• The night float intern will assist you with overnight procedures.

3.3 Weekend / Holiday Day Service
• You will be responsible to round on IM consult services.
• You will carry the consult pager until the call team is done rounding or until noon whichever comes first.
• You are responsible for IM consults until 1pm.
• Your off day is Sunday.

3.4 Weekend Night Service
• You will be covering floor admissions, heme/Onc admissions, IM consultations, clinic calls and BMT questions for the night.
• If capped and called to admit IM clinic patient, State school, and Montford patients, admit patients to precall and sister call teams and notify appropriate teams in AM at check out.
• Your off day is Saturday night.

3.5 Switching Between Nights to Days
• On your day of switch, you will stay until 12:00 p.m the next day and hand off pagers according to flow sheet (~18 hour shift).
• You will be given ~18 hours off to rest before resuming clinical duties at 06:45 a.m the following day.

3.6 Switching between days and nights
• You will re-start clinical duties after ~24 hour rest at 20:45 based on rotating schedule.

4 Subspecialty Services (including Heme/Onc)

4.1 Weekday Day Service
• Arrive at 06:45 am to obtain checkout from night services. You may have new consults done overnight.
• There may be times you will be called to help out with other services. Please refer to flow sheet.
• You shift ends at 17:00 for new consultations/admissions.

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4.2 Weekend Day Service

- You will be able to take either Saturday or Sunday off, arrange with your team/intern.
- Arrive at 06:45 am to obtain checkout from night services. You may have new consults done overnight.
- Notify on call team (at checkout) of your presence.
- You will be responsible for new consultations until 13:00.

5 Jeopardy service

- Resident will perform comprehensive evaluations of new critical care patients. Hours of duty will be 7 am to 12 pm, Monday through Friday. After 12 pm the resident will not be responsible for other patient related activities.
- Resident will carry ICU pager and will do MICU admissions between the hours of 7 am and 12 pm or until the MICU team has completed rounding; whichever comes first. Then the ICU pager will be given back to the MICU senior.
- If another resident in the program must miss duty on an essential service (i.e. floor, MICU, CICU, VA outpatient clinic, resident clinic, etc.), the Jeopardy resident will fulfill these obligations until the absent resident returns for duty. In this case, the Jeopardy resident will not be available to help with duties 1-3 above. The system will revert back to the MICU residents carrying their own pagers.

6 Ambulatory Clinic Service

<table>
<thead>
<tr>
<th>AMBULATORY ROTATION DAILY SCHEDULE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday AM</td>
</tr>
<tr>
<td>Lado</td>
</tr>
<tr>
<td>Monday PM</td>
</tr>
<tr>
<td>Radhi</td>
</tr>
</tbody>
</table>

7 Urgent Care

<table>
<thead>
<tr>
<th>URGENT CARE DAILY SCHEDULE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday AM</td>
</tr>
<tr>
<td>Phy</td>
</tr>
<tr>
<td>Monday PM</td>
</tr>
<tr>
<td>UC</td>
</tr>
</tbody>
</table>
SERVICE OUTLINE INTERNS

1. Floor-Intern Day Intern

- Interns should receive check out between 6:30am and 7:00am from the night float intern. Check-out is mandatory.
- Morning report begins at 8:00am. All residents are required to attend unless there are emergent floor issues to attend to.
- Discuss your cases with your senior before rounds.
- Attending rounds begin at 9:00 or otherwise as dictated by the attending.
- Interns will see up to ten patients per day (unless the senior resident is off in which case the intern is responsible for all of the day’s notes). Distribution of patients is at the discretion of the senior resident.
- On a two intern team the interns will be responsible for all the daily notes as dictated by the senior resident.
- The teaching of the medical students is the job of both the intern and the senior resident. When a student has a question, it is the responsibility of the intern along with the senior resident to answer the question and to teach the students. Please also make a point to teach the medical students key concepts that they should learn on an internal medicine rotation.
- The afternoon should be spent completing work that was discussed on attending rounds.
- If patients are ready to leave, please complete discharge plan prior to the morning rounds with attending so that discharges may be complete by 11am whenever possible.
- Call for the teams is q4. On weekday call (Monday-Friday) the “day-call” intern will start call at 7am until 8pm. Check out with the night float intern will occur each night starting at 7:45 pm or after the ICU intern has checked out.
- The on-call team may take up to 10 new patient admissions or to a cap of 14 patients whichever comes first. The intern and senior resident will share the responsibilities of writing the H&P and placing admission orders.
- In the event that the “day-call” team does not “cap” the remainder of the team’s admission will be completed by the night float team and checked out to the team in the morning.
- Saturday night call will be covered by an intern from one of the day teams as dictated by the call schedule. The Saturday night shift will begin at 7:00pm and the intern will leave no later than 11 am on Sunday after rounding with their usual floor team. Daily progress notes will be written by the intern as usual on Sunday and normal shifts will be resumed on Monday. It is the intern’s responsibility to remember to not work the morning they are assigned to cover Saturday night call.
- The pre-call team is eligible for one new patient transfer or admission up to 1:30 pm
- The sister-call team is eligible for two new patient transfers or admissions up to 3:30pm
2. **Floor Night Float Intern**

- The night float intern will work from 7:00pm to 07:00am Sunday-Friday night (12 hour shift)
- Will attend check-out with the “MICU” and “day-call” intern at 7:00pm each evening and morning check-out with the floor teams each morning from 6:30-7:00 am. The night float intern may leave in the morning once check out to each floor team is completed.
- Responsible for cross coverage of all patients admitted to heme/onc (excluding BMT) and the internal medicine floor teams.
- Responsible for coverage of all ICU patients under the care of the MICU and new admissions to the MICU overnight.
- Will discuss patient care issues with the appropriate night float senior.
- The night float intern will be off each Saturday as per the schedule.
- Assistance with and follow-up of items pending for the on-call and other teams including admission, lab follow-up and procedures.
- Will be responsible for all procedures needing to be done overnight, these should be supervised by the senior resident.
- Will assist the MICU night float senior with the H&Ps and admission orders for all overnight admissions.
- Day off will be off from the end of the shift Friday morning until the start of the shift Sunday night.

3. **MICU Day Intern**

- MICU rounds may begin as early as 7:30 at the discretion of the unit attending. All patient notes should be completed by this time.
- All procedures on a given patient should be performed by the intern caring for that patient whenever possible and must be overseen by a senior resident or attending.
- Log your procedures on Medtrics website as you do them, even after you have reached the certification goal.
- You will be responsible for presenting journal articles and cases at the pulmonary conferences Monday at noon and Friday at 8am as per the conference schedule.
- “Day-call” will be from 7am-7pm and will occur as scheduled. Frequency of call will vary depending the interns scheduled clinic day and the availability of outside rotators.
- The senior resident will be required to see all new patients upon admission along with the intern on call that day. New admission H&Ps will be written by the intern at the discretion of the ICU senior.
- Each intern is to update their patient’s information on the electronic hansoff system using the IPASS format each day before leaving.
- Patients admitted by the ICU night float intern overnight will be distributed among the day-interns each morning.
- Interns will attend check-out each afternoon in the MICU conference room with the ICU team prior to leaving for the day so that pending items may be signed-out to the “day-call” intern.
• All interns should stay until at least 3 pm unless on call.
• Writing patient’s transfer note, orders and verbal check out with floor intern upon patient transfer.
• You are responsible for knowing all the patients on the list. Every patient on the census is your patient.

4. **Hematology and Oncology**
• Interns should receive check out between 6:30am and 7:00am from the night float intern. Check-out is mandatory
• Discuss your cases with your senior prior to rounding
• The team will consist of an attending, oncology fellow, senior resident, and an intern.
• The intern will be asked to see at least half of the patients each day, excluding BMT patients (intern will only see the BMT patients on the weekends when the senior is off).
• The team will cap at 14 patients.
• You may not write more than 10 notes on the weekend.
• Interns will work Monday through Friday 7:00am to 5:00pm and one weekend day from 7:00am to 1:00pm
• Rounds generally begin at 9:00-10:00am in the BMT but exact times will be dictated by the service attending.
• The intern and the senior are required to attend all tumor board meetings which are on Friday at 7:00am in the cancer center conference room. Your senior resident will direct you where to go. The attending may assign you patients to present at the tumor board; these assigned patients must be seen prior to the conference.

5. **CICU**
• The intern will be expected to be in the CICU from 7:00am-5:00pm every day. Rounds will be determined by the attending and the fellow (AM hours may vary depending on the time of attending rounds).
• All patients should be seen and have notes written prior to rounds.
• The intern will be expected to see no less than half the patients to a max of 7 patients per day on weekdays and 10 patients per day on weekends.
• Days off will be on weekends only and will be decided upon by the intern and senior resident.
• Residents will be expected to be in the CICU from 7:00am-5:00pm on working weekend days
• Will assist with writing daily progress notes, H&Ps, consults and admission orders as determined by the CICU fellow.
• All patients are to have follow-up appts made prior to discharge in either the fellow or attending clinic.

6. **ER**
• The schedule will be made by the ER team. You should contact an ER physician (Dr. Piel) 1-2 days prior to starting the rotation in order to set up a schedule.
• You will be required to do 18 shifts during the month (9 nights and 9 days).
shifts are 12 hrs long and begin from 7:00am-7:00pm for the day shift and 7:00pm-7:00am for the night shift.

- All patients have to be checked out with the ER attending to which they are assigned.
- The ER physician will give you patients to see. Do not take charts and see patients without checking with an attending first.
- You are required to attend the noon conference when working the day shift.
- You should not take any night shifts the night prior to/or the day of your clinic because you will still be expected to show up for your clinic as scheduled.
- You are required to attend the Noon conference during the day shift.

7. Electives

- When you are on an elective rotation, you are to follow the schedule of that particular department. You are still required to attend all noon conferences as per the outlined conference attendance schedule.
- You can take your 15 working days/year vacation only during your elective month.
SIGNATURE PAGE

By signing below I acknowledge that I have received and am aware of TTUHSC Internal Medicine Residency Program’s Policies, Rules, Regulations and Service Outlines.

Name:

Date received:

Signature: