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Introduction and Welcome to New Residents and Fellows

On behalf of the faculty, staff, residents and fellows, welcome to the Department of Medicine at the University of Minnesota. We hope the time you spend with us will be both educational and enjoyable.

The Institution Manual contains guidelines and policies that apply to all residents and fellows, unless otherwise noted, throughout the University of Minnesota Academic Health Center. The Program Manual is specific to the Department of Medicine, and policies are written in accordance with the American Board of Internal Medicine and the Accreditation Council for Graduate Medical Education. Policies apply to all educational experiences within the program and are subject to periodic review and change by the faculty, Program Director, Fellowship Director and Department Chair. Each fellowship program will also have their own addendum to the Program Manual, which includes specific information about their training.

The Institution Manual contains information about benefits, policies and procedures that apply to all residents and fellows in a training program at the University of Minnesota. Should information in the Program Manual conflict with the Institution Manual, the Institution Manual takes precedence.

Residents and fellows are responsible for knowing and adhering to the policies and guidelines contained in this handbook. When in doubt, residents/fellows are responsible to contact the program coordinator or director.

Mission Statement / Philosophy

The mission of the Department of Medicine is to enhance the health of the people of Minnesota, the nation and the world, through innovation and research, education and patient care.

It is the mission of the Department of Medicine Residency Program to provide excellent training in the practice and science of Medicine by immersion in patient care, with emphasis upon critical reasoning, scholarship, and professional responsibility, and to promote personal and professional satisfaction.
I. STUDENT SERVICES


COMPUTER TRAINING

Computer literacy is essential to functioning effectively as a physician and with our program. RMS/New Innovations, our web-based residency management suite is used for all evaluations, residents’ portfolios and to log duty hours. Electronic medical record systems are used at each site. It is vital that all residents/fellows are familiar with how to use these systems.

Computer training is available at the University of Minnesota. The Biomedical Library staff present an overview of the services and resources offered through the use of computers, and also demonstrate search strategies for medical practice and research. Using online demonstrations of the Library's online Web forms to request services (e.g., photocopying) and databases to search for health related information (e.g., Medline and electronic journals), residents/fellows can learn how to connect to these resources from within the Library, their clinics, or from home. Information is updated monthly to give residents/fellows access to the most current health topics. The Bio-Medical Library will also assist residents/fellows in any other computer-related issues they might have.

For RMS trainings, contact Gordon Fisher at rgfisher@umn.edu or 612-626-6776.

INTERNET AND INTRANET ACCESS

All Residents and Fellows have internet access through the University of Minnesota. Your login and password are tied in with your email account with the University of Minnesota. To login, go to the University of Minnesota, Twin Cities web site: http://onestop.umn.edu/

Click on “myU Portal” – located in the top, right corner of this page
Enter your X500 (Internet ID) and password
If you are logging in for the first time, and don’t have your password information yet, this page will give you the phone number to call for this information OR you can click on the “Student Internet Account Initiation” button, which is also located on this page.
The “myU Portal” site is the location for general information such as Academics index page, Finances index page, Services index page, and the Help index page, all which give you many resources at your fingertips.

You also have access to your Human Resources information through the Employee Self-Service Web site, www.hrss.umn.edu. This site houses your bi-weekly pay statements and other benefit information. For this reason, it is very important that you logout of the internet when you are done viewing this site, as personal payroll information* is listed here.

E-MAIL

Residents/fellows are assigned a University of Minnesota e-mail account at the beginning of their residency/fellowship. Residents are given their email addresses at intern orientation. Fellows may consult their division for addresses. E-mail addresses can also be found by searching through the University of Minnesota web site at http://search.umn.edu/. Because your University assigned account is listed in the University on-line directory, you are required to use your University email account as your preferred email account. You may not forward your University email account to another email account. We regularly send announcements about the program via e-mail and we require that you log-on every 72 hours or you may miss some important or timely information.
SNAIL MAIL

Some important mailings are sent directly to residents/fellows’ homes. **The Residency Coordinators will forward important mail to you on a regular basis.**

Residents should make sure that the Department of Medicine Education Office has their current home address and phone number at all times. Residents should update addresses with their residency coordinator. Fellows should update their addresses with their fellowship coordinator.

PAGERS

Each resident/fellow will be assigned a universal pager to be carried throughout the training. **Residents/fellows will not have to switch beepers when they switch sites.** Pagers have an 80-mile radius. Batteries for pagers are available at all Medicine Offices at each of the hospital sites. Residents/fellows should turn in their pagers to the UMMC-FV Information desk located in the Lobby if their pager needs repair, and a temporary pager will be assigned. At the end of training, pagers must be turned into the Education Office in 14-124 Phillips-Wangensteen. Fellows must turn their pagers into their fellowship coordinator. Graduating residents: please be sure to hand in your pagers ASAP, as this affects how quickly pagers are assigned to incoming residents!

RESEARCH RESOURCES

Residents/fellows have free access to Medline and other electronic library services. Residents/fellows may gain access from home computers via wireless, modem, DSL, etc., and from computers in the resident rooms at each of the hospital sites. Residents/fellows also have access to workstations in the Reference Area of the Bio-Medical Library in Diehl Hall. Jim Beattie in the Bio-Medical Library can assist with any questions regarding the Health Sciences Libraries. He can be reached at 612-625-4499 or at jbeattie@umn.edu. Software for home computers to connect to the University system can be obtained through the University for a nominal fee.

Residents/fellows may use departmental photocopiers and the copiers in the Medicine Offices at the hospital sites.

RESIDENT ASSISTANCE PROGRAM

(See the Institution Manual for further Information)

Residency training can be stressful for residents and their families. While we formally monitor stress and fatigue, and try to foster a culture of professionalism, warmth and support within the program, there are times when a resident or her/his family may wish to have additional counseling. The Resident Assistance Program (RAP) is a confidential assistance program designed specifically for residents and fellows, and is available to all residents/fellows and their families **free of charge.** Residents/fellows and their families are encouraged to take advantage of this benefit.

RAP offers support and assistance to residents/fellows with issues and problems such as getting a handle on resident debt, dealing with stress, career choices, relationships, and adjusting to residency. RAP is strictly confidential, and is provided by an outside firm, Sand Creek. The RAP program will NOT notify the program or program director of a residents’ use or contacts.

Contact: Sand Creek (the agency) at 651-430-3383 or 1-800-632-7643
For further information regarding the Resident Assistance Program, logon to http://www.med.umn.edu/gme/residents/rap/home.html

**DEPARTMENTAL WEB SITE**
Residents/fellows can access important information through the departmental Web site. The address is for the Residency Web site: http://www.medres.umn.edu/

**DEPARTMENTAL INTRANET WEB SITE**
The department has a Resident Intranet web site that can be accessed by all residents, staff and faculty. To log on, go to the Internal Medicine Residency Web site (listed above)

- Under the menu “Education” on the Left side of the page, click on “Internal Medicine Residency Program”, then “Our Program”.
- On the bottom right, under “Intranet (X500 Protected)”, click on “Internal Medicine Residency”. Enter your x500 (i.e. – cole0266) and password (same as for your email / U of MN Portal login/password and click “Sign In”.
- PLEASE NOTE: this is the same login to your HR info, so be sure to logout as soon as you are finished viewing these intranet pages.
- What can you see on the intranet?
  - Administrative Info
  - Clinic Information
  - Conferences and Workshops
  - Procedure Checklists
  - Directories
  - Global Health
  - Resources and Handbooks
  - Schedules

**USEFUL WEB SITES**

**Bio-Medical Library Web Site:**
http://www.biomed.lib.umn.edu/
Extensive on-line biomedical information, including over 100 medical journals available with full text.

The University of Minnesota also has web sites on campus involvement and events with ongoing information on campus. These web sites are http://www.umn.edu/cic and http://events.tc.umn.edu. Residents/fellows can present their U Card at many of these events for discounted or student rates.

**PROGRAM REQUIREMENTS / GOVERNING BOARDS**

ACGME: http://www.acgme.org/. Please take time to review the program requirements for Internal Medicine training.
ABIM: http://www.abim.org/. Refer to this site for more information regarding board requirements as well as the vacation policy.

**CAREER-RELATED**

There are many web sites dedicated to physician recruitment. Updated lists will be distributed at career night. A sample of those includes:
DEBT MANAGEMENT

The AAMC has a debt management free list serve for residents/fellows designed to help residents/fellows manage their medical student loans. Residents/fellows can subscribe to it by doing the following:

- Send an e-mail to: majordomo@aamcinfo.aamc.org
- In the subject field, provide information and identify your residency program
- In the text section of the e-mail, simply type: Subscribe-moneymatters-your e-mail address

MENTORSHIP

Residents will be assigned a program director advisor (track mentor) in addition to a faculty mentor. Track mentors will focus on general medicine, education, subspecialty medicine or hospital medicine. Faculty mentors will work with residents on an area of focus either within the context of one of the program’s pathways or within a subspecialty area.

The role of the **track mentor** is to:

- Serve as a mentor and advocate for the resident during training
- Review resident’s personal training goals and strategies
- Monitor the academic and professional progress of the resident during training
  - RMS performance evaluations (advisors have access to their advisees’ evaluations)
  - Procedures and log completion
  - Identification of special honors or awards
  - Compliance with RMS evaluations and duty hour reporting
  - Completeness and timeliness of medical records (e.g. discharge summaries)
- Encourage self-reflection and a healthy lifestyle
- Assign a faculty advisor in the resident’s area of interest

The role of the faculty mentor is to:

- Advise resident about selection of rotations and career
- Assist resident with process of fellowship program selection and application
- Provide oversight of scholarly project in a focused area.
- Assist resident in preparing posters or scholarly presentations for meetings, e.g. ACP, ASN, ASH, SGIM, etc.
- Advocate for residents on academic probation or in distress, where needed
- The advisor is responsible for being an advocate for the resident with the Clinical Competency Committee and the Academic Standing Committee.
Residents/fellows must meet with their track mentors a minimum of twice per academic year (this is an ACGME requirement), and should also communicate regularly either by phone or via e-mail. The purpose of these meetings is to review the individual’s Resident Portfolio. This portfolio includes a review of academic records, stress, fatigue, and resources to stay healthy. It also includes self-assessment of stress and sources of professional satisfaction, awards, publications, medical student’s evaluations of teaching and the resident’s self-assessment, personal learning goals, and individualized learning plan (ILP).

Residents will be contacted by their track mentor’s office at the mid-year and year-end point to review semi-annual evaluations. These meetings are required in order to graduate from the Internal Medicine Residency Program.

HOSPITAL EMR PASSWORDS AND ACCESS

EMR passwords and access will be provided at all site locations. Initial login and password information can be obtained through the Education Office at each site:

UMMC-FV: Michael Boland (612-626-5031) for EPIC/Imagecast (UMMC-FV and UMP Primary Care Clinic)
Regions: Karen Lee (651-254-1886)
VAMC: Darlene DeWaay (612-467-4431)

If you have been assigned a login and password for the systems at UMMC-FV, and are having problems logging into these systems, please call the Information Center at 612-672-6805 (for EPIC and Imagecast) or the UMPhysicians Help Desk at 612-884-0884 (for EPIC in the UMP PCC).
If you have been assigned a login and password for the systems at Regions Hospital (EPIC), you may contact Karen Lee or call 952-967-6600 (x76600 in the hospital). At the VA Medical Center (CPRS), please contact Darlene DeWaay or dial HELP from any VA phone.

HIPAA TRAINING

All University of Minnesota Residents, Fellows, Faculty and Staff have to complete HIPAA training sessions through the University of Minnesota, regardless of any other training sessions you may have had elsewhere. HIPAA Training is federally mandated. These training sessions must be completed prior to your residency/fellowship start date.

INSTRUCTIONS:
Log on to www.myu.umn.edu / sign in using your X500 and password (information regarding this can be accessed through this page) / “My Toolkit”

All Residents and Fellows will need to complete the following training sessions:
- Introduction to HIPAA Privacy and Security Video
- Privacy and Confidentiality in the Clinical Setting
- Privacy and Confidentiality in Clinical Research
- Data Security in Your Job
- Securing Your Computer Workstation
- Using University Data
- Managing Health Data Securely
If you have problems accessing the training sessions call the helpline: 612-301-4357

Hours:   Monday – Thursday:    8:00 a.m. – 11:00 p.m.
          Friday:                  8:00 a.m. – 5:00 p.m.
          Saturday:                12:00 noon – 5:00 p.m.
          Sunday:                  5:00 p.m. – 11:00 p.m.

HIPAA     Press “1”; then “2”

Helpful Hints:
   o Load “Flash 6” or later version on your computer before beginning (download from
     macromedia.com)
   o Close all other applications
   o Log-out of “Web-CT” to ensure training is recorded
   o Use DSL versus modem if accessing training from home

Information:
For more information about the University of Minnesota’s Privacy and Security Project and Federal
regulations go to:
www.privacysecurity.umn.edu

II. BENEFITS

MEDICAL INSURANCE
(Please see the Institution Manual for additional medical insurance information.)

All Medical Residents and Medical Fellows must be enrolled in one of two medical insurance plans offered
through the residency/fellowship training program unless the resident provides documentation of other
comparable medical insurance coverage. Please refer to the departmental Medical Resident/Medical Fellow
Benefits Program Booklet for comparison information of premiums and benefits available under each plan.
Please contact the Office of Student Health Benefits at 612-624-0627 or umshbo@umn.edu if you have
enrollment questions or need to make changes in your medical insurance coverage. Questions regarding your
specific policy, such as what is and is not covered should be directed to HealthPartners.

Web site:  http://www.shb.umn.edu/twincities/residents-fellows-medical.htm

DENTAL INSURANCE
(Please see the Institution Manual for additional dental insurance information.)

Optional dental coverage is available for Medical Residents and Medical Fellows only. Family dental
coverage is not available.

Please contact the Office of Student Health Benefits at 612-624-0627 or umshbo@umn.edu if you have
dental enrollment questions. Questions regarding this dental policy, such as what is and is not covered should
be directed to the Delta Dental Customer Service Center at 651/406-5916 or 1-800/553-9536

**LIFE INSURANCE**  
(Please see the Institution Manual for additional life insurance information.)

Forms to request a change of beneficiary may be obtained by contacting the Office of Student Health Benefits at 612-624-0627 or umshbo@umn.edu.

**SHORT-TERM DISABILITY INSURANCE**

Short-term disability insurance is provided, at no cost, to all residents and fellows in the Department of Medicine through Guardian. Enrollment in the short-term disability plan is automatic with no application form required.

Under this policy, a disability is defined as an injury, sickness or pregnancy for which you are under the ongoing care of a physician or practitioner other than yourself. The plan pays for both total and partial disability. This plan has a 15-day beginning date - you must be disabled for 14 days before benefits begin. The plan pays 70% of your base stipend if disabled and benefits can be paid up to 24 weeks. Maximum weekly benefit is $1,000.00.

Maternity Leave  
Under this policy, pregnancies are covered for four weeks after the 14-day waiting period. Payments are made according to the schedule listed below. (Please see Section II in the Program Manual for the departmental leave of absence policies.)

*Days 1-14 (two weeks) of maternity leave: 100% stipend paid by the University  
*Days 15-42 (four weeks) of maternity leave: 70% stipend paid by Guardian

**LONG-TERM DISABILITY INSURANCE**  
(Please see the Institution Manual for complete long-term disability insurance information.)

**PROFESSIONAL LIABILITY INSURANCE**

The Medical Resident and Medical Fellow Professional Liability Insurance policy is administered through the University’s Office of Risk Management and Insurance.

Professional liability insurance is provided by the Regents of the University of Minnesota. The insurance carrier is RUMINCO Limited. Coverage limits are $1,000,000 each claim/$3,000,000 each occurrence and form of insurance is claims made. “Tail” coverage is automatically provided. The policy number is currently RUM-1005-14.

Questions regarding this policy should be directed to Tara Atkisson at 612-625-9995.
MEAL TICKET ALLOTMENT

Meals are provided to residents on call at all sites.

**University of Minnesota Medical Center:** Residents are given a specific allotment when on an inpatient service at UMMC-FV. At the beginning of residency, each resident will receive a meal card containing their total meal allowance for the entire year. This amount was calculated based on the resident’s rotation schedule. Contact Mira Jurich at 612-273-7482 to report a lost or faulty meal card. Please keep this card throughout your entire residency.

Please note: these allotments are *not* meant to provide all meals for your entire rotation. Cards are to be swiped through the cafeteria’s card reader for payment of your meals. Your card is good at the Bridges Cafeteria (8th Floor of the main hospital) or either cafeteria located on the Riverside Campus.

You **cannot** use your card in the doctor’s lounge on the Riverside Campus. Any meals charged from the Doctor’s lounge will NOT be covered by the Department. You may eat in the Doctor’s Lounge, but you will be responsible for all charges.

**Regions Hospital:** Only residents who are on call, serving on general medicine ward rotations and ICU/Nightfloat receives meal allotment allowances of $70 per month.

**Department of Veterans Affairs Health Care System:** A roster will be compiled of all interns/residents coming to the Medicine Service for the month and cash envelopes will be prepared from this approved roster. The Intern/Resident will report to the Canteen Office (in back of Rm 1B103A) before the end of the month of their rotation. Interns have until the 5th of the next month to sign/pick up their allotted money for the month. If you have any questions about your allotted amount, see the Chief Residents as soon as possible. The Canteen Office is open Monday through Friday, 8:00 AM-3:00 PM, Weekends 9:00 AM-3:00 PM.

**Meal Allowances are as follows:**
- Monday through Friday: $8
- Saturday, Sunday & Holiday: $14
- Overnight (Cardiology only): $19

**Canteen Meal Hours:**
- Monday through Friday: 6:30 a.m. – 6:30 p.m.
- Weekends: 9 a.m. – 3:30 p.m.
Canteen is closed on holidays. During the hours the canteen is closed, vending machines can be used.

**PARKING**

Parking is provided at all three sites.

University of Minnesota Medical Center: The department has a specific number of parking contracts that can be used each month. Residents will be issued a parking card to keep throughout their entire training period. That card is to be used **only** while rotating at the University. Parking is not validated for meetings with advisors or the program director. Parking is only provided for workshops or meetings when indicated in the reminder/invitation.

UMMC-FV: Contact Amy Palmer at 612-626-3019.
Regions Hospital: Contact Karen Lee at 651-254-1886
VA Medical Center: Contact Darlene DeWaay at 612-725-2085
**STIPEND LEVELS**

The base stipend levels for the 2014-2015 academic year are:

- PGY1 50,756
- PGY2 52,317
- PGY3 54,117
- PGY4 56,051
- PGY5 58,208
- PGY6 60,251
- PGY7 62,178
- PGY8 64,167

The pay schedule is listed under “Stipends” in section A of this manual. The contact for specific payroll-related questions is Troy Christiansen in Human Resources. He can be reached at 612-626-0119 or chris146@tc.umn.edu. Payroll information can be viewed on the Human Resource portion of your UPortal.

**WHITE COATS**

Each resident is issued two white coats to last throughout residency. Additional coats may be purchased (at the resident’s expense). Please contact Michael Boland (bolan013@umn.edu) to order an additional coat.

**LAUNDRY SERVICE**

**University of Minnesota Medical Center:**
No laundry service is available.

**Regions Hospital:**
No laundry service is available.

**Department of Veterans Affairs Health Care System:**
Residents can pick up a clean lab coat when they turn in a soiled one. They are located in room 1N-104. The laundry service hours are 7 a.m. to 3:30 p.m. Coats are cleaned three days a week: Monday / Wednesday and Friday. Each resident can obtain a uniform request form from the Medicine Office (Darlene DeWaay or Kate Sharpe) in order to pick up his or her coat.

**PHOTOCOPYING PRIVILEGES**

Residents are allowed to use the copy machine located in the Education office on the 14th floor of the Phillips-Wangensteen Building. Residents should keep in mind that if you are copying large projects, please wait until after normal business hours.

**REGISTRATION**

Our Medicine residency program is a professional graduate program leading to professional qualifications, but not an advanced degree. All house staff members are enrolled by their academic plan. Residents are in the IMED Residency academic plan in the Medical School Graduate School of the University of Minnesota and are registered each semester.
TUITION AND FEES

Tuition and fees are being waived at this time. Trainees who are enrolled in the Graduate School pay tuition and fees.

LATE FEES

Any late fees, which are incurred due to holds on registration because of library fines, nonpayment of student loans, or inadequate immunization documentation, are the responsibility of the resident incurring the fees.

U-CARD

The U Card identifies you as a student, staff or faculty member on the Twin Cities campus. Your first U Card is free and can be obtained at the U Card Office located in room G22 in the Coffman Memorial Union building, 300 Washington Avenue SE, Minneapolis / East Bank Campus, Phone 612-626-9900. They are open weekdays: 8:30 to 4:00pm. Bring your driver’s license, state ID or passport and be prepared to have your picture taken.

The U Card is your key to all sorts of campus services and facilities. Your U Card can also be used as your ATM card and your calling card!

Since the U Card never expires, you should hold on to it even after you leave the University. If you ever return as a student, staff or faculty member, your card will still be valid.

Use your U Card for...
  Campus ID purposes
  All your checking needs
  All your calling needs
  Making Gopher GOLD purchases
  Checking out library materials
  Entering the recreation center, golf course, computer labs, buildings, and residence hall dining rooms
  Cashing checks at the Bursar's Office
  Art and athletic ticket discounts (available at place of purchase)
  Accessing art materials, student employment, business school services, and more!

Logon to the TC U Card website for further information the U Card: http://www1.umn.edu/ucard/umtc/tchome.html

III. POLICIES AND PROCEDURES


REQUIRED DOCUMENTATION

Prior to the residency rotation start date, all incoming residents must have turned in or completed the following:

- Copy of Medical School Diploma
- Application for Residency Permit
- Signed Residency Agreement
- Copy of ECFMG Certificate (if applicable)
- Respirator Fit Questionnaire
- Completed HIPAA training online
- VA Application to VAMC
- Immunization Records to Boynton Health Service
- Human Resources Information Form to Troy Christiansen
- Benefits paperwork to the Office of Student Health Benefits

POLICY ON PROFESSIONAL BEHAVIOR AND THE PROFESSIONALISM TRACKER

All residents are expected to conduct themselves in a professional manner at all times and in all interactions with the program, ancillary and administrative staff and within the patient care arena. The University of Minnesota Internal Medicine Residency Program expects its trainees to support and embody the ideals, values and behaviors of professionalism in all aspects of their medical training, including clinical work, educational pursuits, execution of administrative responsibilities and interactions with colleagues, staff, patients and families.

From the Accreditation Council on Graduate Medical Education Core Program Requirements, all residents must demonstrate a commitment to carrying out professional responsibilities and adhere to ethical principles. Additionally, residents are expected to demonstrate:

1. compassion, integrity, and respect for others
2. responsiveness to patient needs that supersede self-interest
3. respect for patient privacy and autonomy
4. accountability to patients, society and the profession; and
5. sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Our program has adopted a professionalism tracking program from Massachusetts General Hospital’s Internal Medicine Residency Program. This program is intended to establish clear professionalism expectations, particularly as they apply to typical resident activities. It also describes a system that will be utilized to assess professionalism, reward model behavior and respond to breeches in professionalism. Lapses in professional behavior will initially be reviewed by the chief residents and/or program directors. We will take a “seek to understand” approach and obtain information from all of the parties involved in a particular episode, including the resident involved. For the initial lapse (provided it is not egregious), residents will receive a reminder about professional behavior and responsibilities. If another lapse in professional behavior occurs, the resident will be referred to the Clinical Competency Committee (CCC), who will review the incident and apply the professionalism rubric below.
PROFESSIONALISM TRACKER

Rating System:
Professionalism will be rated in three (3) general categories: Poor, Expected and Outstanding. These categories will correspond to the following numeric values in the rating scale:
Poor = Below 2  Expected = 2-4  Outstanding = Above 4.0

Each resident starts the year with a score of 3 on the scale, indicating our belief that professionalism is to be EXPECTED of the average physician. The score can change over time. It is not a global rating; rather, it reflects actual observed behaviors.

The score is upgraded for laudable deeds or achievements based on the schedule of points for examples of behaviors listed below.

The score is downgraded for critical behaviors or incidents listed below.

Favorable behaviors – the Resident is given additional points for the following things considered “above and beyond” what is expected: Point Value:
- Program receiving feedback that resident has acted in a manner that is highly professional by patients, staff or their families 1.0 (acts in best interests of the patient; preserves dignity of patient)
- Volunteering for extra duties to ease burden on peers 1.0
- Being identified as someone who very supportive by students, interns, residents, or attending 0.5
- Being identified by a member of the healthcare team as someone who goes above and beyond as working cooperatively as a member of the health care team 0.5
- Demonstrating poise and respect in the handling of a conflict or in adverse conditions 0.5
- Recognizing and reasoning through ethical dilemmas in clinical practice, while respecting cultural and religious beliefs the patient may have that affect his/her choices 0.5

Unfavorable behaviors – the Resident is cited (points are deducted) for including but not limited to:
- Failing to perform assigned duties, or appearing for assigned shifts (i.e. night float coverage, continuity clinic) -1.0
- Forging, fabricating or misrepresenting information -1.0
- Any type of physical violence -1.0
- Missed vacation request leading to last minute clinic cancellation -0.5
- Habitual tardiness/absence to required events such as morning report for a ward resident -0.5
- Being identified as selfish, disrespectful or overbearing by students, interns, residents, or faculty or any member of the health care team (includes offensive email) -0.5
- Being unprofessional according to patients or their families -0.5
- Abusing the back-up system in any way -0.5
  - Not being available when on back-up
  - Harassing a colleague about payback
  - Being rude or offensive to a chief resident when called for back-up
  - Calling in sick to gain coverage for a planned event such as a wedding or interview
  - Arranging to cover someone while on back-up.
- Repeatedly not answering pages or e-mails -0.5
- Non-completion of required administrative tasks such as, but not limited to, discharge summaries, GME surveys, and regulatory paperwork. -0.5
- Not responding to requests from residency administrators and office staff, including the chief residents -0.5
****The CCC has the right to identify additional positive/negative behaviors as necessary that are not included in the list above***

How Applied

1. All incidents, both positive and negative, can be reported to any member of the residency administration, including program directors, chief residents or program coordinators.
2. The program will then be responsible for verifying the specifics in the report. First time offenses (unless egregious) will be reviewed and discussed with the resident and not be referred to the CCC.
3. Egregious reports and repeat offenses will be referred to the Clinical Competency Committee, reviewed and points awarded or subtracted based on the reported behavior.
4. The resident involved will be notified immediately in writing of any change in his or her Professionalism score.
5. A resident who has been reduced to a score of 2.0 will automatically be referred to the Clinical Competency Committee for a formal improvement plan in professionalism.

The Professionalism Score will be reviewed at the semi-annual meeting between the track mentor (PD mentor) and the resident.

If there has been a reduction of the Professionalism Score, an award of 0.5 will be made if there are no further negative reports for 6 months.

The score will be considered in promotion decisions, Chief Resident candidacies and in letters of recommendation from the Program Director.

CONTINUITY CLINICS

Residents are required to attend an assigned continuity clinic one half day per week throughout their entire training. Residents must attend no fewer than 130 continuity clinics during the three years of training. To meet this number, PGY-3 residents may be required to attend clinic sessions outside their normal clinic day. The Medicine Education office monitors the total number of clinics attended throughout residency. Preceptors will evaluate resident performance in clinic twice per year. Residents are expected to participate in the weekly ambulatory care case discussions.

****Please talk with the clinic schedulers and preceptors to confirm your next clinic. This will help avoid any problems in the future. Residents are not allowed to cancel their own clinic without speaking with the Program Coordinator in the Medicine Education Office***

Make-up Policy for Clinic Cancellations:
If you need to cancel your clinic on short notice due to an emergency (i.e. sudden illness), contact Michael Boland and your clinic preceptor to make arrangements to add a make-up clinic. You must also obtain the approval from your rotation director for the absence.

Call and Rotations
- Any clinic cancellations will be determined by the chief residents at each site and relayed to the program coordinator.
- Clinics will be cancelled during late admitting days and on Critical Care rotations.
- Clinics will be cancelled during Night Float Rotations.
- Clinics will NOT be cancelled during Emergency Medicine rotations.
Clinics **will be** cancelled during late admitting days on ward rotations if the resident and intern have the same clinic day assignment, for either the resident or the intern, not both.

**Clinic cancellations for vacations MUST be approved six weeks in advance.** Requests for these cancellations must be submitted in writing via email to Michael Boland at bolan013@umn.edu. Any clinics cancelled due to interviews should be requested one month in advance. Any cancellation that falls within a one-month timeframe must be made up. They will need to contact their clinic scheduler and preceptor to set up a day to see these patients (separate from their normal clinic day). The Medicine Education should office should then be notified of the make-up clinic day.

**Failure to properly cancel clinic will result in a deduction of professionalism points and could potentially result in referral to the Clinical Competency Committee.**

**Holidays**

Each clinic has a different holiday schedule. It is the responsibility of the resident to find out if their continuity clinic is closed for a holiday. It is possible that a resident’s rotation is closed for a holiday, but their continuity clinic in the afternoon is open.

**Vacations**

- Vacation approvals MUST go through Michael in the Department of Medicine Education Office.
- Vacation requests MUST be planned out at LEAST six weeks in advance.
- No more than three clinics per academic year may be cancelled for vacations.
- The resident is responsible for notifying their rotation of any absences six weeks prior to the vacation time. Any vacation requests that fall within the six-week timeframe require the rotation director’s approval in addition to the approval from Michael Boland.
- Family Emergencies and personal leaves will be considered on a case-by-case basis by the Program Director.

**Educational Leave (i.e. Interviews, Medical Meetings, etc.)**

- Although we prefer that you schedule interviews on non-clinic days, **no more than three clinics** per academic year can be cancelled for interviews, medical meetings, etc. If an interview is scheduled within a one-month required timeframe, the clinic must be re-scheduled. If more than three clinics are cancelled, then these clinics will need to be made up on alternate days.
- Your requests must be made to Michael as well as your **clinic four weeks** in advance.

**LEAVE OF ABSENCE POLICIES:**

**VACATION AND SICK LEAVE POLICY**

In accordance with ABIM policy, all residents/fellows will be given one month of leave, to be used for **both** vacation and sick leave. Any leave that exceeds one month will be unpaid and must be made up at the end of the training. **There is no carryover of vacation or sick time from one year to the next.** Training must be extended to make up absences exceeding one month per year of training. For details, please refer to the ABIM policy located on the web at www.abim.org

For sick time, residents are responsible for notifying Michael Boland at 612-626-5031, the chief resident at their site, and the appropriate faculty member of their rotation as soon as possible. Fellows must contact their fellowship coordinator. Sick leave will be approved for legitimate illness.

Vacation time includes 15 weekdays (weekend days are not included in the 15 day count, but are assumed, as vacation can only be taken during a consult month, when weekends are off). Interns are assigned their vacations, a one-week break, and a two-week break, to correspond with their full first year rotation schedule (Interns also receive the last week of their PGY-1 year off). Resident/fellows are allowed to take **one week of**
vacation during ambulatory and elective rotations. (**EXCEPTION**: A resident may take a two-week vacation if it is the non-call half of the University Nightfloat rotation. Vacation taken during those two weeks must be in a two-week block). Any other exceptions to the one full week policy must be approved by the program director. Vacations are not allowed during the Emergency Medicine Rotation at Regions Hospital and during the Global Health Course. Vacation days cannot be carried over to your next academic year.

**Residents:**

Vacation time must be requested via email to Michael Boland six weeks in advance. Upon receiving notice of vacation approval from Michael, the resident must contact their rotation at least six weeks in advance of the time away. It is imperative that the rotation is aware of the absence prior to the rotation start date; individual clinics and lectures are scheduled based on the resident’s time away, clinic day, etc. For rotation contacts, please see the Rotation Contact List on the Current Resident Intranet. Failure to notify rotations of time away may result in a loss of vacation time or added pull schedule time. In special circumstances, vacations may be allowed with fewer than six-weeks’ notice. Such circumstances will be granted on a case-by-case basis and require the rotation director’s approval. All PGY-1 residents will have the last week of their intern year off prior to starting their PGY-2 year.

**PROFESSIONAL AND ACADEMIC LEAVE:**

**Educational Leave of Absence (LOA)**

The Department recognizes the need for senior residents to schedule interviews for post-residency practice or academic positions and also to present scholarly activity. **The program allows G2 and G3 residents to take 5 days of “Educational Leave.”** Educational leave must be scheduled to create minimal disruption to the resident’s schedule. Each resident must make arrangements with their rotation director to take time off for educational leave (see clinic cancellation policy above). Arrangements must be made at least one month in advance of the educational leave if a clinic cancellation is involved. At least one month before the educational leave, you must contact your rotation director, your continuity clinic preceptor, and Michael Boland to make arrangements. It is not advised to take educational leave during an inpatient month; however, if it happens to be the only time, you MUST arrange coverage for yourself.

As a matter of philosophy, the Department discourages interviewing during Internship year. The Department does not expect to, nor can it change the perceived pressure to find jobs after residency training. Interviewing for and selecting academic positions (fellowships or faculty) generally occurs during the second and third years. There is sufficient time in the third year to interview for and select private practice positions. Most importantly, there is much that a resident may experience during the second year, which may influence career choices; contract commitments in the second year may then be premature, yet binding.

**Fellows:**

Please see addendum to the Program Manual for vacation request procedure.

**Unauthorized Leave**

Unexcused or unsupported absences or unauthorized leave and therefore significant tardiness from any mandatory clinical or educational activity constitute unprofessional conduct. Under your signed employment contracts, unprofessional conduct is one behavior which will subject the resident to discipline for non-academic reasons. Unprofessional conduct will result in subtraction of 0.5-1.0 professionalism points from
your professionalism tracker. Such discipline may also result in a written warning, probation, suspension or termination.

**POLICY ON EFFECT OF LEAVE FOR SATISFYING COMPLETION OF PROGRAM**

All residents must meet the thirty-six month training requirements established by the American Board of Internal Medicine before August 31 of the year they intend to sit for the Certification Examination. Residents may miss one month per year, including vacations, sick leave, LOA, etc. Time in excess of three months, whether for vacations, sick leave, maternity or paternity leave must be made up to meet this requirement.

Any request for an LOA/planned leave should be considered carefully, as it will invariably create difficulties for the training program and fellow residents. A requested LOA must be discussed with the Residency Program Director. The Residency Program Director must approve the request at least three months prior to the requested LOA date. Exceptions may be made if the request falls under the definition of the Family Medical Leave Act (FMLA). Please see the Institution Manual for the Medical School policy on FMLA. **Do not assume that an LOA will be granted automatically. Obtain approval before making plans.**

**PERSONAL LEAVE OF ABSENCE (LOA)**

Only under UNUSUAL circumstances, such as a personal or family emergency, will a Personal LOA be granted. Such an LOA will be subject to the general conditions outlined above. All personal time must be made up. Please note this time will be unpaid.

**PARENTAL LEAVE: MATERNITY/PATERNITY LEAVE**

Residents are provided with **6 weeks of paid maternity leave and 2 weeks of paid paternity leave.** Residents should notify the program director as far in advance as possible of the request for personal or maternity/paternity leave. This should be at least 3 months in advance of the planned leave, except in the case of a personal crisis or emergency. Residents are responsible for arranging schedule changes for all other personal leave and should make arrangements as far in advance as possible, in consideration of their colleagues and the program.

When requesting a Leave of Absence, please consider the following:

- The ABIM allows one year of training to be interrupted by only four weeks, including vacation, sick leave, educational leave and Maternity/Paternity Leave.

- Any time off exceeding four weeks will extend your training.

- You will need to complete 36 months of training by 8/31 of the year you intend to sit for the ABIM certification exam.

When taking maternity leave (6 weeks paid) or paternity leaves (2 weeks paid), consider the following:

- This leave time in addition to any vacation time could extend a resident’s training.

- **Maternity Leave** (6 weeks paid):
  - **4 weeks** – If no vacation time was used in the year, no time needs to be made up. And it is paid time.
  - **2 weeks** – This time will need to be made up, but it is paid time

**Anything past this will not be paid and all time over four weeks will need to be made up.**
- **Paternity Leave**: 2 weeks paid
  - 2 weeks – does not need to be made up, paid time
  - **This will then shorten the allowed vacation time from 3 weeks to 1 week.**

Residents are personally responsible for arranging switches in the schedule, and for finding a replacement in their absence, except in the case of an emergency. If a resident has difficulty in making arrangements, please contact the program director for help. The program director must approve any and all personal leave from the program.

**ABIM Policies:**

**Leave of Absence and Vacations**

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.

**Deficits in Required Training Time**

For deficits of less than one month in required training time, ABIM will defer to the judgment of the program director and promotions or competency committee in determining the need for additional training. With program director attestation to ABIM that the trainee has achieved required competence, additional training time will not be required. Trainees cannot make a request to ABIM on their own behalf.

**“Pull” Schedule**

A pull schedule is created on a yearly basis to provide coverage for residents who are unexpectedly unable to serve on their inpatient rotation. Residents are assigned to the pull schedule when they are on a consult or ambulatory month.

If a resident feels they are unable to provide inpatient coverage, they should contact the Chief Resident on call at that site and explain their situation. It will be up to the Chief Resident, with the assistance of program leadership if needed, to utilize the Pull schedule if necessary.

Residents will be on the pull schedule for two week blocks. The resident on the pull schedule is expected to be:

1. Available via pager 24-7 for the entire duration of your time on the schedule.
2. Physically able to perform on an inpatient rotation.
3. Able to be at the site where you are needed within 90 minutes of being contacted.
4. Prepared to take nightfloat if that coverage is needed.

If you are needed for pull and unavailable for any reason at that time, you will be required to provide other pull services in the future to make up for you lack of availability. If this is an unexcused absence (i.e. you forgot you were on pull call and went on vacation) you will lose professionalism points from your tracker. This will also be reflected in your evaluations regarding professionalism.
If you are unable to cover any part of your assigned block on the pull schedule, you may make a switch or arrange for alternate coverage by another resident for a minimum of one week blocks. Shorter “coverage” periods will not be allowed as they impact patient care, education and team dynamics. As with other rotation switches, changes in coverage need to be arranged six weeks prior to the affected period and communicated to the Chief Residents at that time. Switches within six weeks of the affected period can only be approved by the Program Director.

If you are the first pull, the backup pull is NOT available for use if you have something planned during your time on the pull schedule.

The Chief Residents will use your contact information on the Resident Intranet to contact you if you are needed for pull. If this information is inaccurate and you cannot be reached in a time of need, you will be required to provide further Pull coverage in the next block in which you are not on an inpatient rotation.

**DUTY HOURS / DAYS OFF**

Duty hours are defined as all clinical and academic activities related to the training program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. When averaged over any 4-week rotation or assignment, residents/fellows must not spend more than 80 hours per week in patient care duties. As of July 2011, PGY1 residents will no longer work more than 16 consecutive hours. Our program no longer takes overnight call and coverage at night is provided by night float teams.

The program guarantees that residents are provided at least eight-ten hours between all daily duty periods and after in-house call. For senior residents (PGY2 and PGY3) a shorter break may be justified provided it was necessary for safe patient care. These justifications will be monitored by the program director of the residency program and will require documentation in RMS.

Our program’s duty hour assignments recognize that faculty and residents collectively have responsibility for the safety and welfare of patients. Duty hours are ensured by appropriate scheduling of patient care shifts and responsibilities for residents, fellows and faculty. Back-up support systems are provided at each site in the program for times when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. Please refer to the individual sites’ policy manuals for details, or contact the Chief Residents with questions.

In compliance with ACGME guidelines, residents/fellows must take one day off per week, on average, on all rotations. This policy applies to all residents/fellows whether assigned to inpatient wards or consult services. This means that residents/fellows will not have any responsibility to be available on that day. This day off should not occur on a scheduled continuity clinic day. It is the responsibility of the individual resident/fellow, in cooperation with his/her patient care team, to determine the most appropriate day off. Ward interns must obtain the approval of their supervising resident for a day off.

Please refer to the following link for the University of Minnesota’s Graduate Medical Education Duty Hours Policy:

http://www.med.umn.edu/gme/prod/groups/med/@pub/@med/@gme/documents/content/med_content_425171.pdf
Residency Management Suite (RMS)
All residents will receive RMS training during their intern orientation; where the “painting” system will be introduced. Residents are responsible for “painting” in their hours worked. It is expected that residents log in to RMS at least every three days to enter in hours; however, daily entering would be ideal. For all questions related to RMS, please contact Amy Palmer at 612-626-3019 or palm0214@umn.edu or Michael Boland at 612-626-5031 or bolan013@umn.edu. Michael will be checking compliance and will send reminders with deadlines. Painting in duty hours is a program requirement. **Missing the institution deadline twice will result in added time on the pull list as the first pull.** This time will be added on during the resident’s next available consult month. Subsequent missed institution deadlines will result in either additional pull time or a loss of educational allowance funds.

Residents
All residents must have four days off duty averaged over a four week period. This will require that faculty and/or fellows are available to cover the patient care duties on those days.

The program directors and chief residents will monitor duty hours, days off, and adequacy of rest at all sites by reviewing RMS duty hour reports. The program directors and chief residents will review data and residents’ satisfaction with duty hours processes at regular monthly meetings. Attending physicians are responsible for monitoring the duty hours, days off and adequacy of rest, and levels of stress for interns and residents under their supervision, and report any excesses to the chief residents and program directors.

Fellows
Please refer to your division manual for additional information regarding work hours/days off. Please see addendum.

**MONITORING OF RESIDENT WELL-BEING / ADEQUATE REST**

Each inpatient site is responsible for ensuring adequate rest and well-being for its house staff. The chief residents and program directors will monitor duty hours, days off, and adequacy of rest at all sites by monitoring RMS duty hour logs. The attending physicians are responsible for monitoring the duty hours, days off and adequacy of rest, and levels of stress for interns and residents under their supervision, and report any excesses to the chief residents and program director. The program encourages residents to recognize their own levels of stress also, and to seek the advice of their chief residents, attending physician or aid if stress becomes too great.

**ADMISSIONS AND ON-GOING CARE TO INPATIENT TEACHING SERVICES POLICY**

On inpatient rotations or assignments, a first year resident must not be responsible for more than five new admissions per admitting day. A first year resident must not be assigned more than eight new patients in any 48-hour period. A **first-year resident** must not be responsible for the ongoing care of more than ten patients (exclusive of cross cover). When the number of admissions to an admitting team is excessive, it is appropriate for the second-year or third-year resident to assume primary patient responsibility for some admissions.

When supervising more than one first-year resident, the **second, third, (or Med-Peds fourth) -year resident** must not be responsible for the supervision and admission of more than 10 new patients and 4 transfer patients per admitting day, or more than 16 patients in a 48-hour period, nor for the ongoing care of more than 20 patients. When supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients.
It is the responsibility of attending physicians to manage the team census from acceptance of admissions, triaging patients to other teams, and expediting discharges from the hospital.

Residents' service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. (NOTE: "Teaching Service" is defined as those patients for whom internal medicine residents [PGY 1, 2, or 3] routinely provide care.)

ANCILLARY SERVICES

Phlebotomy and Transport: Residents are not required to provide intravenous phlebotomy or messenger/transport services. Those services are provided 24-hours a day at all sites. Residents should contact the chief residents for site-specific details.

AUTOPSIES

University of Minnesota Medical Center:
All autopsy reports are forwarded to the chief resident. The chief resident’s office will forward these reports immediately to the appropriate house staff that are responsible for the care of the autopsied patient. The autopsy secretary or the morgue will notify the chief residents of any scheduled autopsies.

Regions:
Interested parties (house staff, attendings, chief residents) should contact the autopsy technician when an autopsy is being performed on one of their patients in order to set up a time for observation/education.

VA Medical Center:
The house staff is encouraged to attend autopsies. The house staff will receive notification of the autopsy findings.

CHART DOCUMENTATION AND ORDER WRITING

History and Physicals: It is expected that each patient admitted to the hospital will have at least one history and physical written by the intern or resident in the chart by the end of the admitting day. It is NOT required for both the intern and the resident to write separate H & P’s for each admission. If an intern writes a History and Physical, the resident must review and amend the note in the chart. All progress notes and History and Physicals in the chart by students should be read and co-signed by the responsible resident. The supervising resident must write an admission note and daily progress notes on all medical students’ patients. Interns are expected to have sufficient knowledge of their students’ patients to be able to sign out their care to the on-call intern.

Order Writing: In compliance with ACGME requirements, all orders on resident-covered patients must be written by the inpatient house staff. In RARE instances where an attending or consultant resident writes orders, the house staff will be notified in a timely manner. In addition, all orders should be dated and timed to provide better patient care and to protect the resident. Orders by students require the co-signature by the house staff and should be reviewed carefully.

DICTATION POLICY

All discharge summaries are to be completed within 48-hours of discharge from the hospital. If dictations are delinquent, the chief resident at the appropriate site will send the resident a list of the pending dictations and request that they be completed in a timely manner.
If the dictations are not completed within one week of receipt of the letter from the chief resident or if the resident has not discussed a plan of action for the completion with the chief resident, a letter of reprimand will be placed in the resident file. Please note it is the resident’s responsibility to either complete the dictations or contact the chief at the appropriate site for an action plan for any dictation list sent to the resident. If dictations remain undone for two weeks after the letter of reprimand, it will be brought to the attention of the program’s Clinical Competency Committee for review.

Our program has an ongoing Quality Improvement Project on Discharge Summaries and Process. This involves all residents. For details, please refer to the Written Curriculum (www.medres.umn.edu) and log into the Residents’ intranet.

EDUCATIONAL ALLOWANCE

Every current resident in Internal Medicine will receive an educational allowance of $600 per year during their three years of training. Allowance can be used for educational purchases and investments, including:

- Books
- Journal subscriptions
- Medical Software, DVDs, CDs (including Board study guides)
- Travel to scientific and medical conferences
- Computer equipment for medical use (but not cameras, iPhones, iPads, and Tablets)
- Board examinations and Step 3 examinations

Please note: If submitting for reimbursement, residents MUST be in compliance with our evaluation standards, which is having 80% of evaluations completed.

CONFERENCE REIMBURSEMENT POLICY

The Department of Medicine will reimburse residents for the cost of a single meeting during the course of their training up to $1500 provided that you are presenting scholarly work (poster, abstract, workshop, invited presentation). Due to the fact that there are some limitations in funding, this will apply under the following circumstances:

1. Residents must first exhaust the balance of their education account before the Department will reimburse any costs.

2. Residents must be presenting scholarly work (poster, abstract, workshop, invited presentation) in order to be reimbursed.

3. The Department will reimburse for the following expenses above and beyond your educational fund: conference registration, airfare, hotel (up to the limit that is applied to University faculty) and transportation to/from the airport. The maximum amount that will be reimbursed is $1500.00.

4. The Department is not able to reimburse for meals or snacks.

5. If submitting for reimbursement, residents MUST be in compliance with our evaluation standards, which is having 80% of evaluations completed if submitting for reimbursement.
EVALUATION POLICY / NEW INNOVATIONS INSTRUCTIONS FOR FIRST TIME USERS

Complete an evaluation using auto-login link in the email from New Innovations

1. Click the Auto Login link in your notification
2. You may have to copy and paste the link into the web address bar if your email is set to Plain Text instead of HTML.

Use the conventional login by going to www.new-innov.com and sign in

1. On your Home page, scroll down to the **Notifications** section
2. Click the link that states "__evaluations to complete"
3. Click **Evaluate** beside the evaluation you want to complete
4. Complete the questions on the form.
5. If a signature is required, check the box to certify that you are the evaluator.
6. Click **Submit Final**

Please note: If submitting for reimbursement, residents MUST be in compliance with our evaluation standards, which is having 80% of evaluations completed.
ON CALL SCHEDULES

Call schedules for each site are prepared by the Chief Residents at each respective site. These schedules are posted on the Medicine Residency intranet site.

On Call Rooms
(Please refer to the Institution Manual for further information)

University of Minnesota Medical Center:
UMMC-FV has 18 on-call rooms located on the 4th floor of the Mayo building. All rooms have punch code security access which is changed daily, and a security monitor on duty from 2:00PM-8:00AM, and contain a desk, TV, radio clock, and air conditioning. On-call Residents, Medical Students, Fellows, Attending physicians and certain on-call hospital staff are eligible to check-in to a call room. Check-in occurs only during the designated hours of 2:30 PM until 7:00 AM. To check in, go to the desk located in the Resident Lounge (Mayo C-496). The check in desk is staffed by a security monitor during set hours 7 days/week and will require you to present your hospital ID badge. The security monitor will assign you a room, the access code, and the locker room and lounge access codes. All individuals must be out of their rooms by 8:00 AM. Housekeeping will come to begin cleaning by 7:00 AM. If you wish to sleep until 8:00 AM, make sure your DO NOT DISTURB sign is indicated on your door. No room is checked out to the same service two days in a row. Belongings can be picked up any time after 2:30 PM from the security monitor. Any questions, call 612-273-7597.

There are 3 call rooms available in the hospital, and additional call rooms located in the Mayo building, which is connected to the hospital via skyway and tunnels. Call room locations and codes (subject to change):
- MICU nightfloat resident: Room 4-238 (4B) code 5184
- Cardiology nightfloat resident: Room 4-444 (4D) code 5174
- Maroon Medicine Nightfloat (resident and intern) 5A workroom (Room 5120B and 5120C)
- Other (students and off-service residents) Mayo building, call 6126266330 for assistance

Housekeeping cleans the rooms each day at 1:00 p.m.

Regions Hospital:
The call rooms at Regions are located on the 2nd floor in the South tower. To set up a call room, go to the security office on the first floor of the Central section and ask for a call room; rooms can be reserved for up to 6 consecutive nights and will be accessible by a hotel-type keycard given out by security. Request a call room with a computer. A Regions ID badge is necessary to access the general call room area.

Department of Veterans Affairs Health Care System:
Each intern and resident on call has a call room available to them. All call rooms are located on 2B. Keys can be obtained at the Medicine Office from Darlene DeWaay or Kate Sharpe.

HOLIDAY POLICY

Residents should verify any days off due to holidays with their rotation director and clinic site. Not all sites observe the same holidays.
LICENSURE POLICY

Residents are not required to have a Minnesota State License to participate in the residency program, although state law mandates that each resident have a Minnesota Residency Permit. This requires a one-time application and the permit is valid throughout the residency. Questions regarding licensure should be directed to:

Minnesota Board of Medical Practice
2829 University Avenue West, Suite 500
Minneapolis, MN 55414
612-617-2130
www.bmp.state.mn.us/mn_home.htm

GRADED RESPONSIBILITY

It is the responsibility of the Internal Medicine Residency Program Director and the Internal Medicine Faculty to provide residents with direct patient care experience and progressive responsibility for patient management during their residency. *See Table 1: Core Competencies and Progressive Responsibility, Page 30

MOONLIGHTING POLICY

All residents who moonlight must obtain a prospective, written statement of approval from the Program Director. The resident must provide the Program Director with the organization and site of the moonlighting activity, the nature of work (i.e. urgent care, chart review, etc.), the name and telephone number of the immediate supervisor, and the anticipated hours of work per month. The program will also monitor moonlighting on a semi-annual basis by requiring residents to complete a survey and in semiannual meetings with the program directors.

Moonlighting must not interfere with the resident’s performance of patient care or educational responsibilities on any rotation during residency training. In accordance with ACGME and program policy, interns are not allowed to moonlight.

Residents that are actively involved in a formal improvement plan or probation in ANY area of the core competencies will not be allowed to moonlight. If they had been moonlighting previously, privileges will be temporarily suspended. If a resident successfully remediates, moonlighting privileges may be reinstated at the discretion of the Program Director.

Faculty will monitor residents’ performance for evidence of increased stress or sleep deprivation due to moonlighting activities. The program encourages residents to assess their own performances and behavior for evidence of stress and sleep deprivation as well.

Resident/fellows violating this policy may be subject to probation, suspension without pay and/or disciplinary action including, but not limited to, termination. Residents violating this privilege will have their moonlighting privileges revoked for the remainder of their residency.

ACGME policy states that hours spent on moonlighting count towards the 80-hour duty week. However, none of the other constraints of duty hours, such as the 24-hour continuous duty rule and the 10-hour time period provided between daily duty periods, apply.
GUIDELINES FOR PROFESSIONAL DRESS

A set of goals and standards was developed to improve the service we provide to patients and their families. In addition to professional and respectful behavior, it is important that our work habits include proper dress and personal appearance when interacting with patients and their families as well as other colleagues. In addition, you are considered to be role models for future physicians; it is important to set a good example when supervising the medical students. To help meet these goals the following guidelines are outlined below.

- The use of scrubs should be limited to night float, late admitting days, ICU or ED rotations
- When wearing scrubs you should also wear your white coat.
- It is not appropriate to wear scrubs when in clinic.
- Dressing comfortably on the weekends is not an excuse to wear jeans or sweat pants.
- Shoes should be clean and in good condition, no beat-up sneakers.
- Open-toed shoes are NOT allowed in the hospitals or clinics.

PROCEDURE DOCUMENTATION POLICY

Safety is the highest priority when performing any procedure on a patient. ABIM recognizes that there is variability in the types and numbers of procedures performed by internists in practice. Internists who perform any procedure must obtain the appropriate training to safely and competently perform that procedure. It is also expected that the internist be thoroughly evaluated and credentialed as competent in performing a procedure before he or she can perform a procedure unsupervised.

For Certification in internal medicine, ABIM has identified a limited set of procedures for which it expects all candidates to be competent with regard to their knowledge and understanding. This includes (1) demonstration of competence in medical knowledge relevant to procedures through the candidate's ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management, proper techniques for handling specimens and fluids obtained, and test results (2) ability to recognize and manage complications and (3) ability to clearly explain to a patient all facets of the procedure necessary to obtain informed consent.

For a subset of procedures, ABIM requires all candidates to demonstrate competence and safe performance by means of evaluations performed during residency training. The set of procedures and associated competencies required for each are listed below.

To help residents acquire both knowledge and performance competence, ABIM believes that residents should be active participants in performing procedures. Active participation is defined as serving as the primary operator or assisting another primary operator. ABIM encourages program directors to provide each resident with sufficient opportunity to be observed as an active participant in the performance of required procedures. In addition, ABIM strongly recommends that procedural training be conducted initially through simulations. At the end of training, as part of the evaluation required for admission to the Certification Examination in Internal Medicine, program directors must attest to each resident's knowledge and competency to perform the procedures. ABIM does not specify a minimum number of procedures to demonstrate competency; however, to assure adequate knowledge and understanding of the common procedures in internal medicine, each resident should be an active participant for each procedure five or more times.
Competency is required in the following procedures:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Know, Understand and Explain</th>
<th>Perform Safely and Competently</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indications;</td>
<td>Requirements &amp; Knowledge</td>
</tr>
<tr>
<td></td>
<td>Contraindications;</td>
<td>to Obtain Informed Consent</td>
</tr>
<tr>
<td></td>
<td>Recognition &amp; Management of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complications;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain Management;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sterile Techniques</td>
<td></td>
</tr>
<tr>
<td>Abdominal paracentesis</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Advanced cardiac life support</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Arterial line placement</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Arthrocentesis</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Central venous line placement</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Drawing venous blood</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Drawing arterial blood</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Incision and drainage of an abscess</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nasogastric intubation</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pap smear and endocervical culture</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Placing a peripheral venous line</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Pulmonary artery catheter placement</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Thoracentesis</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

It is in the residents’ best interest to maintain an active **Procedure Log in RMS also**. It will serve as the sole source of documentation of procedural training for clinical credentialing following residency.

All procedures should be documented in the Procedural Log Book.
HEALTH INFORMATION MANAGEMENT GUIDELINES/POLICIES ON DOCUMENTATION

**Legibility:** The new policy states that after signing your medical record entry, you MUST print your name and beeper number. In this way anyone having difficulty reading your writing will know who to call for clarification. The Health Information Committee will also be reviewing samples of medical records with entries and will be contacting those identified with illegible handwriting.

**Telephone Orders:** The Medical Staff Rules and Regulations state that telephone orders are to be signed as soon as possible, within 24 hours. Any physician involved in the care of the patient can legally sign telephone orders. **A recent audit showed that only 43% of verbal orders at UMMC-FV are being signed.** To address this problem, staff members who document the telephone order are to place a small flag on the order to alert you of the need to sign the order. Please remember to look for and sign telephone orders when you review charts of your patients on daily rounds.

**MEDICAL RECORDS**

Clinical records that document both inpatient and ambulatory care are to be readily available at all times. Each site provides electronic medical records for patient care. Passwords and access to these records are provided at each site’s orientation during the first day of the rotation.

**SECURITY / SAFETY**

Security and personal safety measures are provided to residents at all locations, including but not limited to parking facilities, on-call quarters, hospital and institutional grounds, and related clinical facilities (e.g. medical office buildings).

**Contact Information:**
- **University of Minnesota Medical Center Security Office:** 612-273-4544 / East Building / Riverside Campus
- **Regions Hospital Security Office:** 651-254-3979
- **University of Minnesota Security Monitor Program:** 612-624-WALK
- **Department of Veterans Affairs Health Care System Security Office:** 612-467-2007 / located on the first floor, in room 1U-162

**SUPPORT SERVICES**

Please see the Resident Inpatient Guides for specific information related to accessing and utilizing these services and systems at all sites affiliated with the Internal Medicine Residency Program. Each of these services must be provided at all sites affiliated with the Internal Medicine Residency Program.

**RADIOLOGY/LABORATORY/PATHOLOGY SERVICES**

Inpatient clinical support services are available on a 24-hour basis at University of Minnesota Medical Center, Regions Hospital and the Minneapolis VA Medical Center, to meet reasonable and expected demands, including intravenous services, phlebotomy services, messenger/transporter services, Inpatient Radiology services including laboratory and radiologic information retrieval systems that allow prompt access to results.
TEACHING ROUNDS

Teaching Rounds take place at all three hospital sites. Teaching rounds, led by the attending or other teaching physician, are patient-based sessions in which a few cases are presented for discussion of clinical data, pathophysiology, differential diagnosis, and specific management of the patient, the appropriate use of technology and disease prevention. Teaching rounds are NOT work rounds. Inpatient teaching rounds take place 4-5 times per week. The teaching sessions include direct resident and attending interaction with the patient and include bedside teaching. Residents should contact the chief resident or attending physician for site-specific schedules.

COMMUNITY SERVICE

There are numerous opportunities for community service and residents are encouraged to take advantage of them when possible. If a resident chooses to participate, please keep in mind the information listed below:

- Clearly identify to the rotation director and program director, the site, hours and goals of the community service.
- Where possible, link the community service to the goals of the rotation. If you are interested in volunteering for a community clinic, organized by the U of Minnesota medical students in the Phillips neighborhood, contact Dr. Brian Sick at 612-626-3109 or sickx002@umn.edu.
- You are encouraged to think beyond direct patient care, to consider public health and social issues.
- At the end of the experience, please provide feedback to the program director. Our goal is to establish an ongoing relationship with the community services sites and it is important that we find out THEIR needs.

VISA SPONSORSHIP

- Visa Sponsorship: The J-1 alien physician visa sponsored by ECFMG is the preferred visa status for foreign national trainees in all UMN graduate medical education programs; therefore, the Internal Medicine Residency Program sponsors only J-1 visas. We do not sponsor H-1B visas. More information on the J-1 visa can be found on the UMN-GME webpage http://www.gme.umn.edu/international/JVisaInfo/home.html.

IV. CURRICULUM OVERVIEW AND PERFORMANCE EXPECTATIONS

PROGRAM GOALS AND OBJECTIVES

The Internal Medicine Residency program at the University of Minnesota represents the strengths and the values of the Department of Medicine: a commitment to compassion and excellence in patient care, a supportive and collegial environment, and distinction in scholarship and education.

Our goals are to train residents to become highly skilled Internists, who will excel in all fields of medicine, from general medicine to subspecialty research; to instill enthusiasm for learning and for the responsibility to continuously and scientifically apply new knowledge to the care of patients; to promote scholarly inquiry;
and to encourage self-reflection and integration of personal and professional values into the daily practice of medicine.

Our educational philosophy emphasizes learning through the care of individual patients, autonomy--balanced with accessible and appropriate faculty supervision, understanding and challenging the limitations in the delivery of patient care, scholarship, and active engagement of residents in program planning and projects.

Please refer to the Program’s Written Curriculum located on RMS for detailed Goals and Objectives and Rotation Descriptions.

ACGME Core Competencies, Milestones and EPA Assessment

Core competencies

Every learner begins their residency training with a set of knowledge, skills and attitudes that they have developed so far in their medical training. Residents gradually acquire these skills over time, starting at the level of a novice and gradually advancing on a trajectory towards independent practice by the end of their training. The ACGME has defined 6 core competencies for trainees in all residency programs. These include: patient care, medical knowledge, practice-based learning and improvement, systems-based practice, professionalism and interpersonal skills and communication.

- **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. This includes demonstration by the resident of effective history, physical examination skills, assessment and interpretation of diagnostic tests, appropriate decision-making, diagnostic and therapeutic interventions, management plans, patient counseling, procedures, application of preventive strategies, and use of information technology.

- **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents will demonstrate in practice, application of basic science and clinical knowledge, as well as analytic approaches to patient care.

- **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Residents will be able to demonstrate application of evidence-based medicine to the care of their patients, critical appraisal of the medical literature, review of patient charts for quality improvement and self-assessment, and skilled use of information technology.

- **Interpersonal and Communication Skills** that result in demonstration by the resident of effective information exchange and teaming with patients, their families, and other health professionals.

- **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents will demonstrate willingness to assess their own actions and reflect upon the nature of professionalism in medicine.

- **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to
The care provided should be of optimal value. This includes demonstration of knowledge in practice of cost-effectiveness, patient advocacy, team-building and health care delivery systems.

**Milestones**

Within these core competencies, the ACGME in conjunction with the ABIM has worked to define 142 curricular milestones that residents that “map” to the core competencies. Individual residents will meet these milestones at different points in their training. These milestones form the core of our assessment tools. They are specific, observable knowledge, skills and attitudes that together reflect a resident’s developing competence within their specialty. See the example below of the curricular milestones for the Medical Knowledge core competency and the approximate time at which a trainee should meet them:

<table>
<thead>
<tr>
<th>ACGME Competency</th>
<th>Developmental Milestones Informing ACGME Competencies</th>
<th>Approximate Time Frame Trainee Should Achieve Stage (months)</th>
<th>Assessment Methods/Tools</th>
</tr>
</thead>
</table>
| Core knowledge of general internal medicine and its subspecialties  
  - Demonstrate a level of expertise in the knowledge of those areas appropriate for an internal medicine specialist  
  - Demonstrate sufficient knowledge to treat medical conditions commonly managed by internists, provide basic preventive care, and recognize and provide initial management of emergency medical problems | Knowledge of core content  
  1. Understand the relevant pathophysiology and basic science for common medical conditions | 6 | Direct observation  
  Chart audit  
  Chart-stimulated recall  
  Standardized tests |
| | 2. Demonstrate sufficient knowledge to diagnose and treat common conditions that require hospitalization | 12 | |
| | 3. Demonstrate sufficient knowledge to evaluate common ambulatory conditions | 18 | |
| | 4. Demonstrate sufficient knowledge to diagnose and treat undifferentiated and emergent conditions | 18 | |
| | 5. Demonstrate sufficient knowledge to provide preventive care | 18 | |
| | 6. Demonstrate sufficient knowledge to identify and treat medical conditions that require intensive care | 24 | |
| | 7. Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions | 36 | |
| | 8. Understand the relevant pathophysiology and basic science for uncommon or complex medical conditions | 36 | |
| | 9. Demonstrate sufficient knowledge of sociobehavioral sciences including but not limited to health care economics, medical ethics, and medical education | 36 | |
| Common modalities used in the practice of internal medicine  
  - Demonstrate sufficient knowledge to interpret basic clinical tests and images, use common pharmacotherapy, and appropriately use and perform September (Issue 1) and December (Issue 2), diagnostic and therapeutic procedures. | Diagnostic tests  
  1. Understand indications for and the interpretation of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis, and other body fluids | 12 | Chart-stimulated recall  
  Standardized tests  
  Clinical vignettes |
| | 2. Understand indications for and has basic skills in interpreting more advanced diagnostic tests | 18 | |
| | 3. Understand prior probability and test performance characteristics | 18 | |

With evolving changes in the accreditation system, the ACGME has further defined 22 Internal Medicine milestones that programs will report upon every six months for each individual trainee (see attachment Intern Medicine Milestone Project). InternalMedicineMilestones.pdf

Resident competence is assessed upon outcomes of training and achievement of these milestones, through multiple assessment methods, throughout the course of their training. In order to achieve these outcomes, the Internal Medicine residency program has developed targeted curriculum, assessments, scholarly opportunities and patient care experiences with the goal of advancement to independent practice by the end of their training. See an example of the NAS (next accreditation system) milestones that all residency programs must report on for their residents every six months.

### 2. Develops and achieves comprehensive management plan for each patient. (PC2)

<table>
<thead>
<tr>
<th>Critical Deficiencies</th>
<th>Ready for unsupervised practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care plans are inconsistently inappropriate or inaccurate</td>
<td>Consistently develops appropriate care plan</td>
<td>Role models and teaches complex and patient-centered care</td>
</tr>
<tr>
<td>Does not react to situations that require urgent or emergent care</td>
<td>Consistently seeks additional guidance when needed</td>
<td>Develops customized, prioritized care plans for the most complex patients, incorporating diagnostic uncertainty and cost effectiveness principles</td>
</tr>
<tr>
<td>Does not seek additional guidance when needed</td>
<td>Recognizes situations requiring urgent or emergent care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seeks additional guidance and/or consultation as appropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriately modifies care plans based on patient’s clinical course, additional data, and patient preferences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recognizes disease presentations that deviate from common patterns and require complex decision-making</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manages complex acute and chronic diseases</td>
<td></td>
</tr>
</tbody>
</table>

**ENTRUSTABLE PROFESSIONAL ACTIVITIES**

The residency program has also developed targeted assessments in key areas of work in internal medicine (entrustable professional activities) including: procedural skills and resident hand offs.
PROCEDURAL EPA- RESIDENTS WILL BE TRAINED ON FIVE BEDSIDE PROCEDURES WITH THE USE OF ULTRASOUND DURING THEIR INTERNSHIP ORIENTATION. ALL RESIDENTS WILL PARTICIPATE IN OUR 1 WEEK LONG BEDSIDE ULTRASOUND SIMULATION COURSE FOR CENTRAL LINES, ARTERIAL LINES, PARACENTESIS, THORACENTESIS AND LUMBAR PUNCTURE. ALL RESIDENTS WILL PRACTICE THESE PROCEDURES ON SIMULATORS AND THEN GO THROUGH A PRACTICAL EXAMINATION WITH FACULTY WHERE YOU WILL BE DIRECTLY OBSERVED PERFORMING THESE PROCEDURES. THIS MUST BE COMPLETED SUCCESSFULLY WITH ADVANCEMENT TO LEVEL 2 ENTRUSTMENT (ABLE TO PERFORM UNDER FULL SUPERVISION) BEFORE YOU ARE ABLE TO PERFORM THESE PROCEDURES IN THE CLINICAL ENVIRONMENT. RESIDENTS WILL ALL BE GIVEN A PROCEDURAL HANDBOOK WHICH YOU NEED TO KEEP WITH YOU AT ALL TIMES. THIS HANDBOOK CONTAINS A LOGBOOK AS WELL AS THE CHECKLISTS THAT WILL NEED TO BE COMPLETED BY YOUR SUPERVISING FACULTY OR FELLOW TO DOCUMENT SUCCESSFUL COMPLETION OF THE PROCEDURES. YOU MUST LOG EVERY PROCEDURE COMPLETED IN THIS BOOK AND SUCCESSFULLY COMPLETE THE CHECKLISTS IN ORDER TO BE ADVANCED TO THE NEXT SKILL LEVEL. IT IS THE GOAL THAT BY THE END OF YOUR TRAINING THAT YOU ADVANCE TO “LEVEL 4-INDEPENDENT PRACTICE” FOR ALL OF THESE KEY PROCEDURES. PLEASE SEE THE TABLE BELOW WHICH DEFINES THE DIFFERENT LEVELS OF TRUST AND THE ADVANCEMENT CRITERIA FOR EACH OF THESE LEVELS. PROCEDURAL DOCUMENTATION IS CRITICAL FOR CREDENTIALING PURPOSES WHEN YOU ARE SEEKING A JOB-SO PLEASE LOG ALL OF YOUR PROCEDURES.
HANDOFF EPA

All residents will be trained in the skill of handoffs during the handoff workshop conducted during intern orientation. This half day workshop will teach you the critical components of the handoff process. Following this workshop, interns will be directly observed by residents, chief residents and faculty throughout their intern year on their knowledge and skills in patient handoffs. Observers will fill out the handoff assessment tool and give each intern direct feedback on their handoff performance. The goal is for all interns to achieve “independent practice” in the area of patient handoffs prior to the start of their 2nd year of training.
The goal of our program is to ensure that each resident has the opportunity to acquire the knowledge; the clinical management and interpersonal skills; the professional attitudes and behaviors; and the experience required to become a proficient general internist.

In order to be board-eligible, the American Board of Internal Medicine sets forth the following requirements during the 36 months of residency training (www.abim.org)

The 36 calendar months of full-time internal medicine residency education:

1. Must include at least 30 months of training in general internal medicine, subspecialty internal medicine and emergency medicine. Up to four months of the 30 months may include training in areas related to primary care, such as neurology, dermatology, and office gynecology or office orthopedics.
2. May include up to three months of other electives approved by the internal medicine program director.
3. Includes up to three months of leave for vacation time.
4. For deficits of less than one month in required training time, ABIM will defer to the judgment of the program director and promotions or competency committee in determining the need for additional training. With program director attestation to ABIM that the trainee has achieved required competence, additional training time will not be required. Trainees cannot make a request to ABIM on their own behalf.

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

1. At least 24 months of the 36 months of residency education must occur in settings where the resident personally provides or supervises less experienced residents who provide direct care to patients in inpatient or ambulatory settings.
2. At least six months of the direct patient responsibility on internal medicine rotations must occur during the R-1 year.

Rotation Requirements by Year of Training

**PGY-1**

- 34-36 weeks inpatient medicine critical care, cardiology, and general medicine
- 4-6 weeks Nightfloat
- 4 weeks emergency medicine rotation
- 4 weeks continuity clinic immersion rotation
- Continuity clinic ½ day per week
- 4 weeks’ vacation

**PGY-2**

- 20 weeks inpatient medicine
- 4-6 weeks Nightfloat
- 8 weeks Adult Health Care and Ambulatory Skills
- 20 weeks elective/consults
- Continuity clinic ½ day per week
- 3 weeks’ vacation plus 5 educational days
PGY-3
20 weeks inpatient medicine
4 weeks Nightfloat
4 weeks UMMC-FV pulmonary medicine (2 weeks inpatient, no call; 2 weeks ambulatory)
24 weeks elective/consults rotations
Continuity clinic ½ day per week
3 weeks’ vacation

The training requirements for the Accreditation Council for Graduate Medical Education can be found on their website by logging on to www.acgme.org. Residents are encouraged to read and become familiar with these special requirements since they are the measure of the program’s success. Residents will be asked in the future to give feedback to the ACGME regarding our compliance. Please understand the requirements and comply with them.

UNIVERSITY OF MINNESOTA INTERNAL MEDICINE RESIDENCY PROGRAM PROGRESSIVE RESPONSIBILITY POLICY

Performance Expectations and Standards for Interns

1. Patient Care
   Inpatient
   ▪ Admit up to 5 patients per call night
   ▪ Will not be assigned more than eight new patient admissions in a 48-hour period.
   ▪ Will not be responsible for the ongoing care of more than 10 patients, when supervised by one resident
   ▪ Write history and physical examinations, assessment and plan notes on all inpatient admissions
   ▪ Write daily progress notes on all of her/his own patients. All notes should reflect the changes in medical status and summarize test results and strategy for the next day. Notes must also be compliant with Medicare billing and documentation guidelines.
   ▪ Have sufficient knowledge of medical students’ patients to provide sign-outs, and discuss with consultants in student’s absence. Have a daily update on medical students’ patients during team work rounds.
   ▪ Write all orders on her/his own patients
   ▪ Are NOT expected to perform admission H &P on Medical students’ patients.
   ▪ Active participant in any hospital codes (not responsible for code leadership)
   ▪ Will admit no fewer than 210 patients during internship

   Ambulatory Medicine
   ▪ Able to see up to 4 patients per half day in continuity clinic
   ▪ Provide appropriate follow up care for patients in continuity clinics
   ▪ Write or dictate notes on all patients

2. Medical Knowledge
   Inpatient Care
   ▪ Interns are expected to demonstrate full command of the details of clinical care on all of their patients, including complete history; physical examination; interpretation of common diagnostic test results including EKG, CXR, basic chemistries, hematologic studies, ABG, UA and body fluid analysis; and consultant recommendations.
   ▪ Cross-coverage: Interns are expected to provide clinical assessment and care of internal medicine patients on the inpatient teaching service when on overnight call. Patient assessment must include sufficient understanding of the patient to provide temporary care of the patient, until the primary resident or team returns to the hospital the next morning.
Interns on the inpatient teams are expected to provide an initial assessment of their patients’ medical conditions, and to initiate diagnostic and management plans after consultation with the supervising resident. After 4 months of medicine internship, interns are also expected to independently initiate diagnostic and therapeutic plans on their patients, including cross-coverage patients, with advice from supervising residents as needed.

- Interns are not expected to obtain consent for autopsy. This is a supervising residents’ responsibility
- Interns should attend and actively participate in morning report, core conferences and seminars

### Ambulatory Care

Interns are expected to be able to evaluate and manage up to 4 patients per half day clinic, under the supervision of their faculty. Interns are expected to demonstrate complete understanding of the details of care on all of their patients, including history; diagnostic test results; and consultant recommendations. Interns are expected to provide an initial assessment of their patients’ medical conditions, and to initiate diagnostic and management plans after consultation with the supervising faculty. By the 7th month of internship, interns are expected to independently initiate diagnostic and therapeutic plans on their patients, with advice from supervising faculty as necessary.

### Scholarly Activity

- **Optional (but encouraged):** Prepare a clinical vignette for the annual Minnesota ACP meeting

### 3. Professionalism

- Strives for patient care and knowledge excellence
- Reliably accomplishes assigned tasks
- Demonstrates integrity, respect for others, honesty and compassion towards patients and members of the care team
- Demonstrates timely completion of documentation and tasks
- Acts as a patient advocate under appropriate circumstances
- Regularly attends conferences

### 4. Communications and Interpersonal Skills*

**Communication of knowledge to learners**

- **Residents** are expected to teach each other and the medical students assigned to their teams. Interns can participate in education of their peers and medical students when time allows. They are expected to share insights into physical examination, history, pathophysiology, basic procedures and any aspect of patient care with their medical students.
- **It is desirable** that Interns provide presentations to their team on medical topics related to any aspect of the care of their patients, at least twice per month on every inpatient rotation. This presentation should be based upon a question raised during the care of patients, should provide references, and if possible, should comment on the quality of the evidence from references.

**Communication with patients and health care team**

- Timely and comprehensive documentation in the medical record
- Effective communication with patients/family members and other members of the health care team regarding plan of care
- Demonstrate sensitivity to cultural/ethnic/gender and differences in sexual orientation
- Successful completion of the CASE (Communication Assessment and Skill-building Exercise) workshop (OSCE)

### 5. Practice-based learning and improvement

- Successfully identifies gaps in knowledge and identifies ways to improve them
- Self-assessment with program director advisor and setting of goals
- Can initiate search of medical literature to answer a clinical question and support their decision making
  - Use of Educational prescription and application to practice
  - With assistance, determine generalizability of findings to particular patient
• Accepts responsibility for care for a panel of patients and appreciates need and role of quality improvement in patient care
• Demonstrates commitment to lifelong learning through participation in 60% of conferences including: morning report, noon conferences, grand rounds, journal clubs and morbidity and mortality conference

6. Systems-based Practice
• Demonstrate understanding of roles of different members of the health care team within local systems
• Works effectively as a member of a multi-disciplinary health care team
• Through participation in activities (i.e. self-assessment, morbidity and mortality conferences), can demonstrate self-reflection and learning on critical incidents/medical errors. Can identify preventable nature of some errors
• Demonstrates knowledge of barriers to effective and safe patient care
• Over time, demonstrates effective financial stewardship regarding ordering of tests and procedures.

PGY-1
By the end of the year, the intern…
- Recognizes when a patient is acutely ill and in need of urgent medical attention.
- Initiates management and stabilize a patient who is in need of urgent medical attention.
- With supervision, demonstrate ability to assess and manage patients with common and complex medical conditions in both the inpatient and outpatient setting
- Identify gaps in their knowledge as they emerge in patient care activities. Develop strategies to address these gaps and plan for improvement
- Maintains comprehensive, timely, legible and appropriately detailed medical records
- Demonstrates efficiency and organization in the care of patients
- Shows compassionate and effective communications with patients, families and health care team, including demonstration of sensitivity to differences in: patients’ race, culture, gender, sexual orientation, socioeconomic status, literacy and religious beliefs
- Is ready to lead an inpatient team, including supervising a new intern and medical student, with the help and oversight of an attending physician

Performance Expectations for PGY-2 Residents
1. Patient Care
   Inpatient PGY-2 Residents...
   - Admit up to 8 new patients per admitting day
   - Will not be assigned more than 8 new patient admissions in a 48-hour period.
   - Will not be responsible for the ongoing care of more than 14 patients, including the interns’ patients
   - Perform a directed history and physical examination on all patients admitted by the interns, review and edit all intern history/physicals as necessary to reflect accurate assessment and management
   - Perform a complete history and physical examination on all patients admitted by the medical students. Write/Dictate an admission note on all medical students’ patients.
   - Reviews management of all of the supervised interns’ patients
   - Addend intern written documentation as necessary to clarify and correct the quality and documentation of the admission note.
   - Write daily progress notes for all of supervised medical students’ patients
   - Cosign all medical student progress notes and orders.
   - Supervise sign-outs of medical student patients
   - Review sign-outs on complicated patients with the on-call resident
   - Obtain consent for autopsy.

Ambulatory/Consultation- residents will see up to 6 patients per half day in clinic, write/dictate notes on all patients. Residents will have the opportunity to add a ½ day of continuity clinic weekly.

In the outpatient setting, PGY-2 residents will be expected to…
expand knowledge of outpatient medicine to include best practice for preventive medicine
Demonstrate sufficient knowledge to evaluate common ambulatory conditions as well as patients presenting with multiple complex medical conditions
Begin to develop knowledge of prioritization of outpatient complaints

2. Medical Knowledge
   Inpatients
   - PGY-2 residents are expected to demonstrate comprehensive understanding of all patients under their care, including history, physical examination, diagnostic test results; and consultant recommendations.
   - Residents on inpatient teams are expected to critique and extend their intern’s assessment of patients, and diagnostic and management plan, and to consult with the attending physician as dilemmas arise. In addition, they are expected to provide primary and secondary references for their teams that address clinical questions or knowledge gaps in patient care.
   - Residents are expected to provide advice to interns on-call. Residents are also expected to provide emergency and urgent consultation for non-medicine services, including, but not limited to management of cardiac and respiratory resuscitation.
   - Residents have a responsibility to directly supervise medical students on their team (see Patient Care, above). Residents are expected to review the students’ histories and physical examinations for accuracy of performance and interpretation of results. This includes demonstration and correction of techniques for both skill sets. Residents are also expected to critique students’ oral presentations and chart notes for format, content, and adequacy of documentation.

3. Professionalism
   1. ongoing participation in at least 60% of conferences
   2. as the team leader, ensures other members of care team are able to participate in conferences manages conduct of work rounds and ensures adequate preparation for attending rounds, demonstrates appropriate professional conduct, including honesty and respect, and serves as a role model for interns and students

4. Communication and Interpersonal Skills
   Communication of knowledge to learners
   - Residents are expected to teach interns and the medical students assigned to their teams. Residents should present topics related to the care of their patients at least weekly on each inpatient rotation
   Communication with patients, advocates and team
   - effectively engages patients and advocates in shared decision making
   - demonstrates effective use of patient education
   - demonstrates effective communication in transitions of care
   - provides clear written plans of care and provides timely discharge summaries in the inpatient setting.

5. Practice-based learning and improvement
   - Ongoing appraisal of knowledge gaps and seeks feedback for improvement
   - Continued self assessment q6 mos with program director
   - Successfully performs search medical literature and use of EBM resources for patient care
     - use of Educational prescription and application to practice
     - clearly articulates clinical questions
     - demonstrates critical appraisal of literature through EBM morning reports
   - Can reflect on patient care quality data and use it to improve patient care
- Demonstrates commitment to lifelong learning through participation in 60% of conferences including: morning report, noon conferences, grand rounds, journal clubs and morbidity and mortality conference
- Takes responsibility for supervision of team and effectively integrates teaching, evaluation and feedback into their role

6. System-based medical practice
- Demonstrates ability to coordinate patient care and transitions of care across multiple health care settings
- Demonstrates understanding of mechanisms for analysis and correction of systems errors
- Works with members of the health care team to anticipate risks of and prevention of medical errors

Scholarly Activity
Residents are expected to expand their roles and responsibilities as teachers in scope and frequency by the following:
- Present Journal Club at least once during the academic year.
- Present the results of research done during residency at the annual Minnesota ACP meeting or the Department of Medicine Research Day or
- Prepare a clinical vignette for the annual Minnesota ACP meeting in November or
- Prepare senior talk on scholarly activity (overseas Global Health experience)

PGY-2
By the end of the year, the resident…
- Independently assesses and initiates management of very ill inpatients and all outpatients
- Shows insight and judgment in most clinical situations
- Recognizes and manages most new clinical situations skillfully
- Models compassionate and effective communications with patients, families and health care team
- Demonstrates continuous improvement in patient care, through analysis of own practice and performance
- Seeks appropriate learning resources and consultation

Performance Expectations for PGY-3 Residents
The PGY-3 year is designed to provide trainees with opportunities to take a variety of elective rotations in subspecialty and general medicine, as dictated by the individual resident’s learning needs and career goals. This requires residents to reflect upon their strengths and areas for improvement, with help of feedback form their program director advisor, faculty mentors, and the Medicine In-Training Examination results. Their training is based upon the premise that all residents’ training is to become a complete Internist, no matter their final career plans. All residents must have clinical experience in each of the subspecialties in Internal Medicine including: cardiology, critical care, endocrinology, gastroenterology, geriatric medicine, hematology, infectious diseases, nephrology, oncology, pulmonary disease, and rheumatology.

The final year of training is also a time to polish and develop teaching, scholarly, and systems-based medical practice skills in preparation for independent practice of medicine or fellowship. The curriculum provides a platform for achievement of these goals by providing 7-8 periods of elective rotations, and 5-5.5 periods of inpatient rotations.

Scholarly activity-
- Present Journal Club at least once during the academic year.
If not done in the PGY-2 year….

- Present the results of research done during residency at the annual Minnesota ACP meeting or the Department of Medicine Research Day or
- Prepare a clinical vignette for the annual Minnesota ACP meeting in November or
- Prepare senior talk on scholarly activity (i.e. overseas Global Health experience)

The expectations for performance of PGY-3 is as described for PGY-2 residents with the following additions:

**Patient Care**

- Senior residents will serve as the supervising resident on general internal medicine wards, cardiology and critical care at one of our teaching sites.
- Recognition of more complex disease process that deviates from the norm (“zebras”)
- PGY-3 residents will provide the majority of medical-decision making for all patients in these settings with decreasing amount of input from faculty. By the end of the year, residents will be able to function independently of faculty
- Senior residents will provide code leadership and guidance for more junior colleagues
- Will effectively provide initial stabilization and ongoing management of critically ill patients

**Medical Knowledge**

- Demonstrates sufficient knowledge to evaluate medically complex patients
- Demonstrates understanding of pathophysiology of complex medical illness
- Has sufficient knowledge of other disciplines including: ethics, health care economics and behavioral sciences.

**Professionalism**

- Serves as a model of professional behavior for junior colleagues and students
- Effectively advocates for patient needs
- Upholds ethical standards of profession and within research/scholarly activity
- Recognizes and manages conflicts of interest

**Communications and Interpersonal Skills**

- Communicates effectively with the most challenging patients and families with minimal direction
- Coordinates team communication to optimize patient care
- Functions as effective team leader with decreasing reliance on attending
- Demonstrates ability to sort through conflicting consultant recommendations and formulate a treatment plan

**Practice-based learning and improvement**

- Appropriately integrates EBM with expert opinions and professional judgment.
- Able to systematically compare practice patterns to larger populations and seek to improve disparities in own patient care
- Ability to accurately self-assess skills and performance.
- Continually demonstrates improvement and effectiveness in leading team
- Participation in QI project during AHCC rotation

**Systems-based medical practice**

- Actively participates and able to provide leadership in multi-disciplinary/discharge rounds.
- Functions as a leader in bedside rounding.
- Acts as a role model for patient-centered care
- Able to identify systematic barriers to patient-centered care and partners with other professionals to propose improvements

**PGY-3**

**By the end of the year, the PGY-3 resident…**

- Practices as an independent physician
- Effectively evaluates the performance of junior residents and medical students
- Demonstrates exceptional knowledge of basic and clinical sciences
- Demonstrates comprehensive understanding of complex relationships and mechanisms of disease
- Can implement primary and secondary preventive strategies for various disease states
- Incorporates teaching into practice
- Uses evidence from scientific studies to improve patient care
- Understands the limits of her/his knowledge and seeks appropriate learning resources and consultation when necessary
- Models “Reflective Practice”: the continuous assessment of personal and systems’ performance to improve patient care

**Inpatient Team: Responsibilities by Year of Training**

<table>
<thead>
<tr>
<th>PGY-1</th>
<th>PGY-2</th>
<th>PGY-3</th>
</tr>
</thead>
</table>
| Admit up to 5 pts/call  
Patient cap of 10  
Admission H&P and note all patients  
Follow all Medicine Clerkship patients with team  
Direct bedside exam QD  
Daily progress note all patients  
Write orders on all patients  
Know all student patients  
Sign-out all patients at the end of the day | Admit up to 8 pts per call  
Patient cap of 14  
Brief Admission H&P on Intern admissions  
Full Admission H&P on all student patients  
Lead team work rounds QD  
Daily progress note on all medical student patients  
Cosign discharge note and orders on all student patients  
Directly supervise all intern and student patients  
Supervise sign-outs of medical student patients  
Review sign-outs on complicated patients with the on-call resident  
See PGY1 | Admit up to 8 pts per call  
Patient cap of 14  
Coordinate bedside teaching for students  
Assign and research medical and patient-related topics for team teaching sessions  
See PGY-1 and PGY-2 |

**SUPERVISION POLICY**

Internal Medicine Residency training in our program is designed to promote the professional growth and development of residents from novice physicians to highly skilled Internists. This occurs through the care of hundreds of individual patients, under the supervision of expert faculty. Residents acquire increasing responsibility designed by a sequence of rotations, and continuously adjusted to the needs of the resident and patients. It is our program’s deeply held philosophy that physicians learn best when they are as autonomous as their knowledge, skills and attitude permit in the care of patients. That level of autonomy varies for each
resident and each patient. Our faculty is ultimately responsible for patient welfare and safety, and therefore supervises all patient care encounters in the ambulatory and inpatient settings for all residents. **Faculty are on call and available to their residents 24 hours a day and 7 days a week for supervision and consultation, during every clinical experience and rotation.**

**ACGME Internal Medicine Milestones**

Your performance on each rotation will be evaluated based on the Internal Medicine Milestones created by the ACGME. Please see the following link to review these milestones. 
http://www.acgme-nas.org/assets/pdf/Milestones/InternalMedicineMilestones.pdf

**Non-Teaching Patients Policy**

The admission of and continued care of patients by residents is limited to those on the Internal Medicine teaching services at all three sites. The only exceptions are for emergency care of off-service patients in life-threatening situations.

**Teaching Medical Students**

The Department of Medicine has a major responsibility for guidance of student development throughout the four years of medical school, and the Medicine Externships (Medicine 7-500 and 7-501) are integral to the overall educational process designed to foster clinical competence. There are significant differences in emphasis between the two clerkships. It is essential that all residents understand the Course Objectives and schedule as they relate to their particular student(s). This will enable both student and teacher to share the same goals and to establish reasonable expectations and will allow the process of evaluation to be fair and objective.

Setting expectations should be an initial activity. We encourage you to sit down with all learners and teachers (students and residents and attending) to set expectations on Day 1 of rotation. This should include:

1-Go over the student and resident schedule to understand what will take them off the ward (conferences, clinic, and days off)

2-Understand learners’ goals

3-Set a schedule of times you will round

4-Tell students what you value/expect in student performance (3rd year students should be at Reporter moving toward Interpreter, 4th years should be at Interpreter moving toward Manager)

5-Consider having students and/or residents prepare a mini-talk (5-10”) on subject related to their patients

Feedback is one of our most important responsibilities as educators. Feedback should be provided at midpoint of **your** rotation and at the end of your time with learners. Try first asking the learner about **their** assessment of their performance. Follow this with your observations about skills, attitudes and behaviors (be specific). Include any suggestions you may have for improvement. For the students include your assessment of where they are performing in the O-R-I-M-E scale and what they need to do to move to next level. At the end ask the learner if he/she understands or has any question about the feedback. Any potentially serious
deficiencies or problems perceived in student performance should be brought to the attention of the hospital coordinator as early in the rotation as possible.


**Observer**
- A Student who is “shadowing”/passive
- This does **not** meet criteria for passing a 3rd year student

**Reporter**
- The “what” questions
- Able to prioritize patient problems
- Appropriate differential dx (3 reasonable possibilities)
- Interprets data as test results come back
- Demonstrates skill in selecting the clinical findings which support possible diagnoses
- Should be an active participant in patient care

**Interpreter**
- The “Why” questions
- Able to prioritize patient problems
- Appropriate differential dx (3 reasonable possibilities)
- Interprets data as test results come back.
- Demonstrates skill in selecting the clinical findings which support possible diagnoses
- Should be an active participant in patient care.

**Manager**
- The “how” questions
- Proposes and selects appropriately among multiple diagnostic and therapeutic options
- Tailors treatment plan to fit patient circumstances, taking into account concurrent diagnosis and treatments, psychosocial factors and patient preferences.

**Educator**
- Reads deeply and shares new learning with others
- Defines important questions to be answered and has the drive to look for and evaluate evidence needed to guide therapy
- Is an effective and accurate source of information for patients and families.

The clerkship committee expectations of students are detailed in the evaluation forms found on E*Value. Upon completion of the first medical externship (Medicine 7-500), the student should be able to conduct a complete general physical examination and appropriate special examinations. In addition to identification of relevant symptoms and physical findings, the student should know the pathophysiologic basis and clinical correlates of these findings for problem identification and problem solving, and based upon a reasoned differential diagnosis be able to plan an adequate diagnostic evaluation using principles of evidence-based medicine. Students in the second medical externship (Medicine 7-501) will continue to practice and develop these skills and begin to participate responsibly in the management and treatment of patients.

**An effective way to encourage independent learning is to use rounds as a stimulus.** Faculty and residents are encouraged to provide students with positive direction through both questions and assignments. Identify “knowledge gaps” which are directly important to care of current specific patients and assign students to do a
(5 minute) mini-talk on the topic during attending rounds in two days. Students really value the opportunity to develop some focused expertise, contribute to teaching and to patient care. Every encounter, clinical or conference should provoke discussion, questions, and the mutual search for answers. Preparation by students prior to ward rounds, seminars and tutorials is necessary because they will actively participate with student colleagues and faculty in solving problems. Faculty can frequently help by suggesting additional source materials or direct literature searching to aid in the student’s search for information.

For more information, visit the Internal Medicine Clerkship web site: http://www.dom.umn.edu/education/internal-medicine-clerkship/index.htm. Here you will find course objectives, teaching resources for faculty and residents, and a link to the RED (Resident Educator Development) program.

RESEARCH AND SCHOLARSHIP ACTIVITY

Scholarship is integral to the understanding and practice of Internal Medicine. We expect all residents to engage in scholarly activities informally throughout their residency. The requirements for scholarship include:

Scholarship in Residency

- **All residents must, by the end of their residency, give a formal presentation in the form of an abstract or clinical vignette submitted to the ACP Regional Meeting.**

- **Any resident who has taken a scholarly month** abroad should submit an abstract to the ACP Regional Meeting (or alternatively, make a presentation at the Tropical Medicine Seminar).

- Please note that any poster submitted to the ACP Regional Meeting may also be submitted to another research or scientific meeting as well (we strongly encourage this!)

Optional and highly encouraged opportunities:
- International rotation
- Research—up to 3 months during training
- Clinical vignette poster presentation at Regional ACP or SGIM meeting
- Research poster presentation at Regional ACP meeting or other subspecialty meeting nationally
- Please note that a maximum of three rotations can be done over the course of residency that are considered electives. These include the global health course, research and international rotations.

If submitting for reimbursement, residents MUST be in compliance with our evaluation standards, which is having 80% of evaluations completed if submitting for reimbursement.

The program requires all residents to participate in journal clubs. PGY-2 and 3 residents are required to prepare and facilitate a journal club at least twice with the help and advice of faculty members at each site.

All residents are encouraged to make a formal and informal presentation of clinical and/or scientific topics throughout their training as determined by rotation and subspecialty-specific goals.

The Department of Medicine is now able to reimburse residents for the cost of a single meeting during the course of their training up to a $1500 maximum provided that you are presenting scholarly work (poster, abstract, workshop, invited presentation). Due to the fact that there are some limitations in funding, this will apply under the following circumstances:
3. Residents must first exhaust the balance of their education account before the Department will reimburse any costs.
4. Residents must be presenting scholarly work (poster, abstract, workshop, invited presentation) in order to be reimbursed.
5. The Department will pay reimburse for the following expenses above and beyond your educational fund: conference registration, airfare, hotel (up to the limit that is applied to University faculty) and transportation to/from the airport.
6. The Department is not able to reimburse for meals or snacks.

RESEARCH

Residents who wish to do research during their residency are encouraged to do so no sooner than their 2nd year of training. Mentored research opportunities abound, and faculty are eager to include residents on their projects or to support new focused areas of inquiry. Research may include any scholarly area of inquiry into the basic or applied sciences, clinical medicine, epidemiology, medical education, history of medicine, quality improvement or health services. Research must be conducted under the guidance of an experienced faculty mentor. Research can be done at any of the teaching sites, but most experiences are at UMMC-FV and the VAMC. Interested residents should contact Nacide Ercan-Fang, M.D. at ercan001@umn.edu. She will be able to connect residents with the appropriate resources to get a project underway.

The Clinical Research Center at UMMC-FV has special funding to support clinical investigation by residents. All clinical research requires residents to apply for Institutional Review Board (IRB) approval. Faculty at the CRC are experienced in this process, and will guide the resident through the application. Residents are encouraged to begin looking for a project and a faculty mentor during the winter of internship. The Education Office will send announcements and applications for Research Rotations to all residents annually in February. All residents who take a research elective must complete an application form and obtain the approval of the Program Director. Paper evaluations will be sent out for these rotations.

Residents who perform research are required to present their results at the annual Regional American College of Physicians (ACP) meeting in November and at the annual Department of Medicine Research Day in May, as part of their Senior Talk requirement, or at a National Meeting.

Residents who choose a research career may elect to participate in the Physician Scientist Pathway. For more information visit: http://www.medres.umn.edu/program/physicianscientistpathway/home.html

CONFERENCES, WORKSHOPS AND SPECIAL SESSIONS
FOR INTERNAL MEDICINE RESIDENTS

The program provides a wide variety of conferences and seminars for residents. In addition to morning report, rotation specific conferences, and teaching rounds, the program provides Core Conferences (156 hours per year), grand rounds (each site, 52 hours per year), morbidity and mortality or CPC conferences (each site, 52 hours per year), and Journal Clubs with literature review activities (12-24 hours per year). In addition, the program provides 38 hours per year of other seminars and workshops covering both general medicine and the internal medicine subspecialties: Teaching and Leadership (18 hours per year), Communications (4 hours), Professionalism (12 hours), End of Life Care (4 hours), and Career Planning/Preparation (12 hours).
The core conferences (program, GME and rotation-specific) cover the major topics in general internal medicine and the internal medicine subspecialties; and are repeated every 18 months. Some are available for review electronically (website). The topics include: adolescent medicine, clinical ethics, medical genetics, quality assessment, quality improvement, risk management, preventive medicine, medical informatics and decision-making skills, law and public policy, pain management, end-of-life care, domestic violence, physician impairment, and substance-use disorders; and are available to residents at each of the program’s participating institutions. Conferences also include information from the basic medical sciences, with emphasis on the pathophysiology of disease and reviews of recent advances in clinical medicine and biomedical research.

**Attendance Policy**
All residents are required to attend a minimum of 150 hours of conferences per year in addition to morning report. Morning report occurs 4 days per week at each site, one of which is designated for Interns. Interns are required to attend Intern morning report weekly, and are welcome to attend and participate in all morning reports. Residents are required to attend all morning reports, with the following exceptions:

- After Nightfloat shifts
- During Adult Health Care Clinic rotation—has separate, primary care conferences
- VA and UMMC-FV Cardiology—separate conferences
- Off-site rotations
- During Consult/Elective rotations, residents are required to attend 2 morning reports per week.

When this schedule conflicts with the rotation-specific clinics, it is the responsibility of the resident to choose days that interfere the least with CLINIC.

It is desirable that each resident attends at least 60% of these conferences. All workshops and seminars are required. The Program considers conference attendance to be a reflection and measure of residents’ professionalism, and tracks attendance for individual residents.

**A typical week is outlined below:**

**University of Minnesota Medical Center**
- Morning Report: 8:15-9:00 AM Monday, Wednesday & Friday for residents, Tuesdays for interns
- Grand Rounds: 12-1 Thursdays
- Mortality and Morbidity Conference: 12-1 Fridays
- Core Conference Series: 12-1 Tuesdays and Wednesdays
- *Research Conference: 12-1 Mondays
- *Professor’s Rounds (Firms A, B, C, D only): 11-12 Thursdays

**Regions**
- Morning Report: 9:30-10:30 AM Monday, Tuesday, Thursday, Friday
- Grand Rounds/CPC: 12-1 Wednesdays
- Core Conference Series: 12-1 Monday, Tuesday, Thursday
- Clinical Conference: 12-1 Friday

**VA Medical Center**
- Morning Report: 8:00 – 9:00 AM Monday and Tuesday
- Grand Rounds: 12-1 Fridays
- Morbidity and Mortality: 12-1 Wednesday
- Core Conference Series: 12-1 Monday and Tuesdays
- *Research Conference/Journal Club: 12-1 Thursdays

*Optional, but encouraged*
WORKSHOPS AND OTHER SPECIAL SESSION DESCRIPTIONS FOR RESIDENTS

1. **Journal Clubs**—2 per month at each major teaching site, both directed by PGY-3 or 4 residents with scheduled faculty supervision/mentorship. This provides a key interactive and self-directed format for learning the principles and application of evidence-based medicine. Coordinated with program-wide EBM curriculum.

2. **Adult Health Care Clinic conferences (AHCC)/ Ambulatory Skills**—These conferences are provided during this required 3 month primary care block rotation in the PGY-2 (occasionally PGY-3) year. Topics are specific to the primary care setting. Go to Internal Medicine Residency website for full list of topics.

3. **Resident Workshops**—(45 hours/year)
   - **Professionalism:** Half day workshop 3 times per year, by PGY level of training (12 hours/year)
   - **Physical diagnosis:** Half day workshop 3 times per year, by PGY level of training (15 hours/year)
   - **End of life care:** Full day annual workshop in November for all Interns (7 hours/year)
   - **Transition to residency for PGY-1’s:** Half day workshop on teaching, leadership, systems-based medical practice, evaluation, update on the program’s ACLS “CODE” Quality Improvement project; June annually (5 hours)
   - **Preparation of a scholarly presentation:** Half day workshop on PowerPoint™, preparation of a talk, scientific poster preparation. (4 hours)

4. **Other Special Sessions**
   - **Subspecialty Career Night**—fellowship program directors and division directors advise residents on career choices, planning, and strategies.
   - **CME Courses**—Annual orthopedics course on sports medicine for Primary Care Physicians. 2 CME sessions per year are permitted. The CME office also holds an annual spring event for residents about career planning.

THE GLOBAL HEALTH PATHWAY

Our program has a strong and long tradition of international medical study. Spearheaded by Director, Patricia Walker, M.D. and by Medicine Pediatrics alumnus, Bill Stauffer, MD, MPH, and in cooperation with the University of Minnesota Medical School, we have created the Global Health Pathway for residents.

This Pathway includes Continuity Clinic experience at the Center for International Health, a HealthPartners clinic, Monthly Tropical Medicine Seminars, the ASTMH course and an International scholarly experience. Details are available under the “About our Program” link on the Medres Web site. Residents may choose an international rotation from the following sites: Chiang Mai, Thailand, Arusha, Tanzania, Bangalore and Manipal/Mangalore in India and Costa Rica. This activity is considered a scholarly activity, and residents must complete an application form that specifies goals, project, and faculty mentor. Residents will be evaluated via a paper evaluation form sent with the resident. Residents are required to make a presentation about their rotation at the Regional ACP meeting, the Tropical Medicine Seminar, at the Department of Medicine Research Day in June, or as a Senior Talk. Only those residents planning to sit for the ASTMH certification exam are considered in the Global Health Pathway.

The American Society of Tropical Medicine and Hygiene (ASTMH) course is offered in the summer months of July and August (exact dates vary by year). PGY-2 and PGY-3 level residents are eligible to take this course, but only in one four-week block per year. Interns are not permitted to take this course. Also, vacation requests will not be granted during this course. Any time gone, including attending continuity clinic, will need to be made up by attending the Tropical and Travel Medicine Lecture series. For more information on the specifics of the pathway, please contact Debbie Luedtke at 612-625-3268 or luedt047@umn.edu
PROCEDURES REQUIRED FOR CERTIFICATION IN INTERNAL MEDICINE BY THE AMERICAN BOARD OF INTERNAL MEDICINE (www.abim.org)

For certification in internal medicine, the ABIM requires that candidates must be judged competent by their program director in the procedures listed below:
1. Interpreting electrocardiograms
2. Performing the following procedures; understanding their indications, contraindications, and complications; and interpreting their results:
   - Advanced cardiac life support
   - Abdominal paracentesis
   - Arterial puncture
   - Arthrocentesis
   - Central venous line placement
   - Lumbar puncture
   - Nasogastric intubation
   - Pap smear and endocervical culture
   - Thoracentesis
The Board recommends three to five as the minimum number of directly supervised, successfully performed procedures; confirmation of proficiency is not credible with fewer procedures.

ROTATION AND CALL SCHEDULES (www.medres.umn.edu)

Call Schedule for Medicine Inpatient Sites

<table>
<thead>
<tr>
<th></th>
<th>Interns</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>UMMC-FV Subspecialty</td>
<td>Q5</td>
<td>Q5</td>
</tr>
<tr>
<td>UMMC-FV ICU</td>
<td>Q5</td>
<td>Q10</td>
</tr>
<tr>
<td>UMMC-FV Gen Med Firm</td>
<td>Q4</td>
<td>Q4</td>
</tr>
<tr>
<td>UMMC-FV Nightfloat</td>
<td>--</td>
<td>QD 0.5 month inpatient</td>
</tr>
<tr>
<td>UMMC-FV Pulmonary Firm</td>
<td>--</td>
<td>QD 0.5 month inpatient/0.5 month ambulatory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No night or weekend call</td>
</tr>
<tr>
<td>VAMC Cards/ICU</td>
<td>Q4</td>
<td>Q4</td>
</tr>
<tr>
<td>VAMC Gen Med</td>
<td>Q5</td>
<td>Q5</td>
</tr>
<tr>
<td>VAMC Gen Med/Nightfloat</td>
<td>--</td>
<td>QD</td>
</tr>
<tr>
<td>Regions Gen Med Wards</td>
<td>Q4</td>
<td>Q4</td>
</tr>
<tr>
<td>Regions ICU</td>
<td>QOD</td>
<td>QOD</td>
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<tr>
<td></td>
<td>No night call</td>
<td>No night call</td>
</tr>
<tr>
<td>Regions Night Float</td>
<td>--</td>
<td>0.5 month</td>
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</tbody>
</table>

The Medicine annual rotation schedule process takes place from February through June. Schedule request forms are mailed to the residents in February and actual scheduling begins in March. Via the request form residents can rank their preferred electives/consults, and are also asked to list three “Wishes”. The scheduling team will do their best to grant all wishes, however, it is not always possible.

Once the schedule has been released, there will be a brief window where changes can be made. Residents must keep in mind that for funding purposes, you have to make an even swap, i.e. if you are scheduled for UMMC-FV and want to go to Regions, you must find someone from Regions to go to UMMC-FV. Please note that once a rotation switch has been agreed to and the coordinator and/or chiefs have been notified, the
switch is considered final. Coverage works in a similar way. If a resident agrees to cover a portion of someone else’s inpatient time, the coverage is considered final as soon as the Chief Residents/Coordinator is notified of it. If the resident who agreed to the coverage can no longer do it, it is the responsibility of that resident to now find their own coverage.

The chief residents at each site create the call schedules. They will also include a list of clinic cancellations that will be sent to Michael Boland, who will forward on to the clinic schedulers. Call schedules are posted on the Internal Medicine Residency intranet site (www.medres.umn.edu) or please stop by either the site-specific chief’s office, or check with the residency program coordinator to get copies.

V. EVALUATION AND ADVANCEMENT POLICY

Principles
Evaluation is an essential to professional development and growth during residency training. While we provide regular formal evaluation by faculty and peers, we also assert that self-evaluation and “reflective practice” is vital to understanding of one’s own strengths and areas for improvement as a physician. Our program encourages residents to seek informal feedback from trusted colleagues, nurses, patients, chief residents, faculty, formal advisors and the program directors. Each resident will also choose (or be assigned) a Mentor/Advisor.

Formative Evaluation
Each resident and fellow’s competency in medical knowledge, patient care, professionalism, communication and interpersonal skills, practice-based learning and improvement and systems-based medical practice is monitored and evaluated on an ongoing basis. Evaluation of residents includes written evaluations by the teaching attending physician and resident colleagues via New Innovations/RMS, a web-based reporting system (see below). Residents and fellows must also formally evaluate attending physicians (via RMS), other residents and interns, and the sites and rotations.

It is important for residents to meet with faculty at the beginning of each rotation to discuss rotation goals. Faculty is required, in accordance with ACGME policy, to provide verbal feedback to residents at the end of each rotation or assignment. Residents are also encouraged to seek out faculty feedback regularly.

Summative Evaluation
Each resident meets twice yearly with their faculty advisor to review performance evaluations, conference attendance, procedural logbooks, and summaries of students’ teaching evaluations; to prepare individual learning goals; to update a list of scholarly presentations and manuscripts; and to provide feedback to the program. Advisors are an excellent resource for career planning, as well as advice on dealing with the stresses of residency as well. Original copies of these mid and year-end evaluations are placed in the resident’s individual file and are readily accessible for their review.

All residents also evaluate the entire program via an annual “year-end program evaluation.” The results of this annual evaluation are available at each hospital, and an executive summary is sent to every resident. In addition, the program directors meet with residents rotating at each hospital site monthly for open discussions. All program evaluations are reviewed and used for continuing improvements to the program and rotations.
### Program Directors’ Ratings of Clinical Competence

<table>
<thead>
<tr>
<th>Components and Ratings</th>
<th>PGY-1, PGY-2, and MP-3</th>
<th>PGY-3 and MP-4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Clinical Competence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfactory</td>
<td>Full credit</td>
<td>Full credit</td>
</tr>
<tr>
<td>Marginal</td>
<td>Full credit for one marginal year. Repeat one year if both PGY-1 and PGY-2 are marginal</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>No credit, must repeat year</td>
<td>No credit, must repeat year</td>
</tr>
<tr>
<td><strong>Moral and Ethical Behavior</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfactory</td>
<td>Full credit</td>
<td>Full credit</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>Repeat year or, at the Board’s discretion, a period of observation will be required</td>
<td>Repeat year or, at the Board’s discretion, a period of observation will be required</td>
</tr>
<tr>
<td><strong>Components of Clinical Competence</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfactory</td>
<td>Full credit</td>
<td>Full credit</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>Full credit</td>
<td>No credit, must repeat year</td>
</tr>
</tbody>
</table>

*The six required components are 1) patient care (which includes medical interviewing, physical examination and procedural skills), 2) medical knowledge, 3) practice-based learning and improvement, 4) interpersonal and communication skills, 5) professionalism, and 6) systems-based practice.*

### USMLE Step 3

All residents must pass the USMLE Step 3 exam by January 1st of their PGY-2 year. Residents should apply for the exam no later than July 18th of their PGY-2 year. Residents should complete the exam before October 1st in order to receive results by the January 1st deadline.

### IN-TRAINING EXAMINATION

All residents are required to take the In-Training Examination. The Department pays for this exam for each year of training. The results of the test assist residents as well as the residency program director to identify strengths and weaknesses of both the resident and the training program. The Exam is taken in September of each year. The Education Office will make assignments based on call and continuity clinic assignments.

### NEW INNOVATIONS/RMS—WEB-BASED EVALUATION SYSTEM
The New Innovations/RMS evaluation system is intended to disseminate the summarized and confidential results of hundreds of evaluations by residents in order to continue to strengthen and refine the program’s teaching, curriculum and clinical experiences.

- All residents are expected to complete their evaluations of rotations within two weeks of completion of the rotation. Note that RMS is intended to complement and not replace direct feedback at the end of each rotation.
- All faculty are expected to complete their evaluations of residents within two weeks of completion of the rotation. All faculty are expected to provide end-of-rotation feedback to the residents.
- Each month, New Innovations will automatically notify rotation directors that residents’ evaluations are available for them to review. Access will be permitted by New Innovations after 3 or more evaluations have been completed, to provide confidentiality to the evaluating residents.
- Evaluations of individual resident performance and of individual faculty performance will remain strictly confidential and will not be disseminated throughout the program.

If at any time you forget your password, user name or have difficulties with New Innovations, contact Michael Boland at 612-626-5031 or via e-mail at imedeval@umn.edu. You can also obtain your password by putting your email address (U of MN assigned) and login into the Request Password feature, located on the main login page of New Innovations: https://www.new-innov.com/login.

**EVALUATION COMMITTEES**

The **Clinical Competency Committee** (CCC) and **Academic Standing Committee** (ASC) monitor resident performance and address problems or concerns. The CCC is chaired by Dr. Nacide Ercan-Fang and is comprised of the program director, associate program directors, a core faculty member from each of our teaching sites, chief residents and a PhD educator with expertise in assessment. The CCC serves two main functions:

1) to monitor resident performance and develop tailored improvement plans for individuals as necessary
2) To report resident performance and progress to the Accreditation Council on Graduate Medical Education as part of the Next Accreditation System twice yearly.

The CCC meets monthly to review the progress of all residents within our program. Residents are identified for review based upon: low scoring performance evaluations, as well as concerns expressed by faculty members, chief/supervising residents or ancillary staff. All meetings and discussions are strictly confidential. Minutes are kept of each meeting by the program director.

The CCC will, when necessary to improve a minor problem with a residents’ performance, refer a resident to his /her advisor or to one of the Associate Program Directors or Chief Residents for informal remediation. If the performance deficiency is deemed more serious, or is recurrent, then the resident will be referred to the CCC for creation of a formal performance improvement plan (PIP). This involves stating performance deficiencies and working with the resident to define an improvement plan within a set period of time. Terms of the PIP may include a referral to a physician, or a counseling psychologist in the Residents’ Assistance Program (RAP) for further evaluation of possible physician impairment. It is the responsibility of the CCC to monitor the outcomes of the PIP. A copy of the PIP is placed in the resident’s file. A copy of the PIP will also be provided to the resident. The CCC does have the ability to recommend extension of training (internship and/or total length of training) for residents if this is deemed to be beneficial for their clinical skills.
Progress reports on all residents under improvement plans are reviewed by the CCC monthly. If a resident makes some measurable progress towards the defined goals, the period of improvement may be extended. If the resident fails to meet the expectations of the PIP, they may be placed on probation and may be referred to the Academic Standing Committee at the discretion of the CCC. If a resident in placed on probation, this becomes a permanent part of the training record and must be reported to boards and other licensing/credentialing bodies. The length of probation will be determined by the CCC in conjunction with the Program Director. If a resident is determined to be unsuccessful in improving during the probationary period, they may, at the discretion of the CCC, be referred to the Academic Standing Committee for consideration of dismissal.

The Academic Standing Committee (ASC) is an ad hoc committee of faculty members representing our three teaching sites, with experience in residency education and evaluation. The ASC convenes at the recommendation of the CCC and Program Director under several circumstances: 1) the resident has failed performance improvement and the CCC is requesting guidance, 2) a serious breach of trust or deficiency in performance has occurred with a particular resident, or 3) a resident has failed Probation and the Program Director/CCC is considering dismissal.

The resident and an advocate of his/her choice may attend the open session of the ASC. The committee provides a forum for residents to address judgments of academic deficiency or misconduct and reviews all academic competency and performance issues, including the resident’s ERAS application and undergraduate medical school transcript and letters of recommendation, as well as the resident’s academic file, before making formal recommendations to the program director. The Program Director is responsible for action on all resident competency issues. The Program Director attends the ASC meetings, but is not a voting member of the committee. Written policy for ASC is included in the Residency Contract Agreement.

Possible outcomes of the ASC include but are not limited to: continued and redefined improvement plan, medical and/or psychiatric appraisal, extension of residency training period, continued probation with certain rotations to be repeated, non-renewal of contract, and dismissal from the program. A final written summary of the resident’s progress is entered into the resident’s file.

Reporting of Performance to the American Board of Internal Medicine

Summaries of all residents’ performance evaluations are provided, as required, to the ABIM annually. The Board’s criteria for promotion are used as a guideline for the program director (see also Evaluation Committees, below).

International Rotation Evaluation

Residents doing any type of overseas rotation or rotation away outside the University of Minnesota Internal Medicine Residency Training Program must first get permission from the program director to ensure there is adequate funding. The resident must then complete a form which includes the goals and objectives for the rotation as well as information on where they will be and contact information. A paper evaluation will be sent with the resident to be completed by the faculty supervisor at that site. The resident is responsible for making sure that the evaluation is turned back to the Education Office in a timely manner.

Research Rotation Evaluation

Residents participating in research will be evaluated by the principal investigator with whom they are working.

VI. DISCIPLINARY AND GRIEVANCE PROCEDURES


House Staff Substance Use/Abuse Policy
It is the policy of the University of Minnesota that University personnel will be free of controlled substances. Chemical abuse affects the health, safety and well being of all members of the University community and restricts the ability of the University to carry out its mission. Similarly, the Department of Medicine recognizes that chemical substance abuse or dependency may adversely affect the physician-in-training’s ability to perform efficiently, effectively and in a professional manner. The department believes that early detection and intervention in these cases constitutes the best means for dealing with this social problem and creates the best environment for providing improved patient care. Accordingly, the following policy has been adopted.

A. No resident shall report for assigned duties under the influence of alcohol, marijuana, controlled substances, or other drugs including those prescribed by a physician which affect his/her alertness, coordination, reaction, response, judgment, decision-making abilities, or adversely impact his/her ability to properly care for patients.

B. Engaging in the use, sale, possession, distribution, dispensation, transfer or manufacture of illegal drugs or controlled substances may have a negative impact on a resident’s ability to perform his/her duties; therefore, no resident shall use, sell, possess, distribute, transfer or manufacture any illegal drug, including marijuana, nor any prescription drug (except as medically prescribed and directed) during working hours, while on rotation at any hospital or institution participating in the training program.

C. Any violation of this policy may subject the resident to discipline, including, but not limited to, suspension and/or termination.

D. When there is a reasonable cause to believe that a resident may be using, selling, possessing, distributing, dispensing, transferring or manufacturing any illegal drug, controlled substance, or alcohol, the resident may be required to undergo medical evaluation and assessment. The resident’s ability to continue participation in the program will be determined by the Residency Program Director in consultation with attending faculty or the Resident Review Committee and the Chair of the Department. Action may include, but is not limited to, recommendation for treatment and return to duty, suspension from duty with pay, suspension from duty without pay, and/or termination.

E. Depending upon the circumstances, the department may notify appropriate law enforcement agencies and/or medical licensing boards of any violation of this policy.

F. Residents who are convicted of a criminal drug statute violation (including DWI, boating tickets, etc.) are required to inform the Residency Program Director or Resident Review Committee or Department Head of this conviction (in writing) within five (5) calendar days.

G. Other residents who have reasonable cause to believe that a colleague is using a substance that adversely impacts on the resident’s performance in the training program must report the factual basis for their concerns to the Residency Program Director.

H. If a resident is taking a medically authorized substance which may impair his or her job performance, the resident must notify his or her supervising resident, chief resident, attending faculty or the Residency Program Director of his or her temporary inability to perform assigned duties.

I. The policy of the American Board of Internal Medicine maintains that physicians who have a history of chemical dependency, as reported to the Board, and who submit documentation acceptable to the Board that their disease is known to be under control, can apply for and take the certifying examination. Candidates who have a current problem of chemical dependency, as reported to the American Board of Internal Medicine, will not be issued a certificate upon completion of all requirements for certification unless they submit documentation that their disease is known to be under control for five (5) years from the time of the most recent occurrence of the disease.

J. Residents are encouraged to seek assistance in addressing any problems they might have related to alcohol or substance abuse. The services of the Fairview University for Children Employee Assistance Program, Physicians Serving Physicians, and the Minnesota Association of Public Teaching Hospitals Resident Assistance Program are available to all residents and their families. (Please refer to the Institution Manual for contact numbers and descriptive information on these programs.)
K. Residents must be aware that there are significant criminal penalties, under state and federal law, for the unlawful possession or distribution of alcohol and illicit drugs. Penalties include prison terms, property forfeiture, and fines.

**ACADEMIC GRIEVANCE POLICY**
*(Please refer to the Institution Manual for Medical School Policy)*

**GRIEVANCE PROCEDURES**
The following is an outline of the general scheme proposed for the resolution of grievances which may arise within the residency program. Detail and clarification must be added as the various elements of these proposals are accepted or rejected or replaced with alternative. These guidelines or policies are confined to the process within the Department of Internal Medicine with the assumption that appeal of the final action or decision coming from the intradepartmental process will remain a viable option once the departmental grievance process has been completed.

**Principles**
1. Definition of the legitimate areas of disagreement to be covered by these procedures.
2. Provision of ascending levels of recourse with potential for final resolution of the conflict at each of these levels without prejudice to any rights of involved individuals.
3. Adherence to the principles of due process, academic freedom and fairness.
4. Procedures to be readily available and expeditiously.
5. Inclusion of a system of advocacy.

**Grievance Committee for the Internal Medicine Residency Program**
1. The committee is ad hoc. Appointed by the Head of the Department with representation of faculty, and affiliated hospital if pertinent, and one or all of three PL ranks of the residency program as well as chief residents as appropriate.
2. All action of this committee are considered advisory to the Head of the Department of Internal Medicine.
3. All actions of this committee are by a simple majority vote with a quorum present. A quorum consists of one-half of all the named members of the committee, plus one.

**Areas of Potential Grievance Covered by these Guidelines**
The areas of possible grievance to be resolved by the following procedures will include, but not be limited to, the following:
1. Evaluation of resident performance by the faculty.
2. Assignment or definition of house staff duties.
3. Interpretation and implementation of other policies and guidelines, such as those included in this document.
4. Resident-resident conflicts.
5. Resident-chief resident conflicts.
6. Resident-faculty conflicts.
7. Chief resident-faculty conflicts.

**Potential Parties to the Process**
1. Principals in the complaint.
2. Mentors, as advisors and advocates.
3. Grievance committee.
4. Department Head and/or a designee.

**Grievance Resolution Process**
As defined here, resolution will be considered an outcome deemed acceptable to the principals to the complaint. When resolution is reached, no further steps in the process will be taken and the matter will be considered closed. This policy assumes that any single principal to the grievance retains the right to carry the process forward by denial of resolution, and to appeal the intradepartmental decisions to extra-departmental grievance procedures.
Steps in the Process:

1. Review of complaint with mentor or other ad hoc advisor.
   **Outcome:** resolved OR taken to step 2

2. Informal discussion with other persons deemed appropriate by parties to the complaint.
   **Outcome:** resolved OR taken to step 3

3. Formulation of a formal written complaint.

4. Forwarding of complaint to the grievance committee, with copies to principals to the complaint and to the head of the department.

5. Committee review of the complaint with consultation and written minutes, but without tape recording.
   **Outcome:** resolved with report to the head of the department OR taken to step 6

6. Department Head reviews the grievance committee actions and recommendations and then advises the parties to the complaint of his decision as to the dispensation of the complaint action.
   **Outcome:** resolved OR taken to step 8

7. Appeal to the Medical School and the appropriate extra-departmental grievance process.

VI. GENERAL AND ADMINISTRATIVE INFORMATION

*(The Institution Manual is designed to be an umbrella policy manual. Some programs may have policies that are more rigid than the Institution Manual in which case the program policy would be followed. Should a policy in a Program Manual conflict with the Institution Manual, the Institution Manual would take precedence.)*


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