THE UNIVERSITY OF
TENNESSEE
HEALTH SCIENCE CENTER.

COLLEGE OF MEDICINE
CHATTANOOGA
INTERNAL MEDICINE

Internal Medicine Residency Program Guidelines

2024 – 2025

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UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE CHATTANOOGA MISSION AND VISION STATEMENT

The University of Tennessee College of Medicine Chattanooga (UTCOMC) will be a top-tier medical education/ health sciences institution.

Mission

The mission of the UTHSC College of Medicine Chattanooga is to facilitate and support the education, research, and service goals of the College of Medicine at the University of Tennessee Health Science Center.

Goals

We will educate the future leaders in the field of medicine, "Blending the Art and Science of Medicine", and thus, reduce the burden of human illness and suffering.

Vision Focus Areas

Quality Education - UTCOMC will provide the highest quality of state-of-the-art education for Medical Students, Residents, Fellows, and practicing physicians in an integrated, multidisciplinary environment. Faculty will be recruited, supported, and retained to teach, engage in scholarly activity/ clinical research, and provide the highest level of healthcare for area patients.

- ✓ Cutting Edge, Nationally Recognized Research: Recognizing that medical education must be built on a strong scientific foundation, faculty and students will engage in scientific research projects for the purpose of improving health and reducing the burden of illness globally.
- ✓ Health Enhancements for Greater Chattanooga Area (and beyond): The region will have improved health outcomes due to the work of the UTCOMC. Many of the institution's students will choose to stay in the region to practice; thus, our excellence translates into better regional healthcare.

Values

Excellence: Superior performance will be expected from all Faculty, Staff, and Medical Students, Residents, and Fellows.

Fiscal Responsibility - Fiscal soundness will be the basis for all decisions regarding resources and how those resources are best utilized.

Compassion and Social Responsibility: Faculty, Staff, Medical Students, Residents, and Fellows will embrace the reason we are here: to contribute to health care one individual at a time. We will never lose sight of the fact that we serve individuals and their families, and they depend on us for their wellbeing.

Diversity: UTCOMC will recruit, educate, and graduate an increased number of underrepresented minorities, and we will work to reduce health disparities that exist for persons of color.

Health Access: UTCOMC will work with physically and mentally challenged individuals and organizations advocating for these individuals to ensure access to top- level health care is available for those who may not be able to navigate through and access health services for themselves.

Medical Community Integration and Enhancement: Recognizing that medical education is best when information is shared among the medical disciplines, UTCOMC will offer educational opportunities where all students, whatever their areas of specialty, will work together and learn that a collaborative medical community is a necessity.

Collaboration

The UTHSC College of Medicine Chattanooga will work to support the Strategic Plan of the University of Tennessee Health Science Center.

ERLANGER HEALTH SYSTEM MISSION AND VISION STATEMENT

Mission: We compassionately care for people.

Vision: Erlanger is a nationally acclaimed health system anchored by a leading academic medical center. As such we will deliver the highest quality, to diverse populations, at the lowest cost, through personalized patient experiences across all patient access points. Through innovation and growth, we will sustain our success and spark economic development across the Chattanooga region.

Core Values:

Excellence **-** We distinguish ourselves and the services we provide by our commitment to excellence, demonstrating our results in measurable ways.

Respect **-** We pay attention to others, listening carefully, and responding in ways that demonstrate our understanding and concern.

Leadership **-** We differentiate ourselves by our actions, earning respect from those we lead through innovation and performance.

Accountability **-** We are responsible for our words and our actions. We strive to fulfill all our promises and to meet the expectations of those who trust us for their care.

Nurturing **-** We encourage growth and development for our staff, students, faculty, and everyone we serve.

Generosity **-** We are giving people. We give our time, talent, and resources to benefit others.

Ethics **-** We earn the trust by holding ourselves to the highest standards of integrity and professional conduct.

Recognition **-** We value achievement and acknowledge and celebrate the accomplishments of our team and recognize the contributions of those who support our mission.

INTRODUCTION

This document contains the University of Tennessee College of Medicine Chattanooga Internal Medicine Residency house staff rules. Please thoroughly read this document to understand your responsibilities to your patients, your attendings and your fellow residents. This document encompasses rules and policies that you should be not only aware of but always adherent to during your time as a resident in addition to all guidelines and pertinent policies of the University of Tennessee College of Medicine Chattanooga and Erlanger Health System. If a question arises, please consult this manual first as the answer is often just a few pages away. While an attempt has been made to cover all situations and to outline all house staff responsibilities, inevitably some details may be missing. Also, this manual is always a "work in progress." Change is constant in residency programs and often must be made during the year as deemed necessary to improve the program.

The most important guiding principal for the University of Tennessee College of Medicine Chattanooga Internal Medicine Residency program is the education of our residents. We will always strive to provide the most progressive educational experiences. However, we will always have to coordinate educational and service needs within both the college and the Erlanger Health System enterprise, and, most importantly, our educational program must follow the Accreditation Council on Graduate Medical Education (ACGME) mandates. If there are any problems with compliance, they must be reported to the residency program director immediately.

PROGRAM MISSION STATEMENT

The University of Tennessee College Of Medicine Chattanooga Internal Medicine Residency Program is committed to training resident physicians in providing compassionate, evidence based care to diverse patient populations using a curriculum that supports individual resident well-being and empowers a community of future physician leaders. The program will provide a diverse and inclusive academic environment that will fully prepare our graduates for individualized careers in primary care, hospital medicine, academic medicine, and subspecialty training. Residents will be immersed in an environment that fosters teamwork and appreciates high standards in patient safety and quality improvement. The goal will be to produce highly capable board-certified internists well rooted in the principles of lifelong learning and of academic inquiry/scholarly activity who can adapt to a dynamic, ever changing health care environment. We will uphold and embrace the highest professional standards in individual comportment while providing patient care and serving as physician leaders that impact not only the individual patient but our community.

PROGRAM AIMS

- To provide, learn, and exemplify the highest standards in patient care by compassionately treating patients with complex medical conditions.
- To promote the health and well-being of the local community of Chattanooga and the surrounding area.
- To support the research mission of our institution, including contribution to clinical knowledge in our scientific community as well as quality improvement initiatives institutionally.
- To uphold excellence in lifelong learning and medical knowledge, including but not limited to Internal Medicine Certification.

- To treat all patients, hospital staff, and colleagues with professionalism, kindness, and respect.
- To foster an environment of inquiry within oneself and with junior colleagues.
- To recognize stewardship of medical resources.
- To uphold the standards of University of Tennessee College of Medicine Chattanooga Internal Medicine Residency Program throughout our professional careers through leadership, lifelong learning, and commitment to excellence in patient care.

COMMITMENT TO DIVERSITY AND RESIDENT RETENTION

The program will continue to ensure diversity beginning with a non-biased selection process. The program is open to applicants from accredited US (allopathic and osteopathic) and Canadian medical schools and International Medical Schools that meet standards of licensure for the state of Tennessee (when not able to be determined the program director uses standards employed by the California Board of Medical Licensure as they generate an accessible and complete listing). There is no preference given in respect to age, class, ethnicity, gender, physical and mental abilities, race, sexual orientation, spiritual practice, and other human differences - all are given equal footing in the selection process. We only ask that applicants pass USMLE steps 1 and 2 (CK and CS), have done well in medical school with recent experience, and demonstrate sufficient performance judged by both residents and faculty during an in-person onsite interview. The rank list is made by the program director aligning with the ideals and strives to align with individuals who want to join our program and will successfully complete our curriculum. Once a resident is enrolled in our program, we invest in every individual the full array of mentorship and advising resources we can to make sure the curriculum is individualized when possible and provides longitudinal support for residents among peers, staff, and faculty members. Individualized learning plans and strategies for success are highlighted in mentor meetings and reinforced during semi-annual reviews. Progression along the milestones is also visible to all residents via evaluation tools and informatics produced by New Innovations. The program has invested in all individuals matched into our program and above all else we will strive to make sure every intern progresses sufficiently to the point they can graduate, be licensed, and pass the ABIM certification examination.

The program and its sponsoring department align with our accrediting college of medicine and health system in terms on inclusiveness and fostering diversity. Both have officers for diversity and human resource practices that support a diversified faculty and staff population. There is no preference given to candidates with respect to age, class, ethnicity, gender, physical and mental abilities, race, sexual orientation, spiritual practice, and other human differences. The department has a history of a well-diversified faculty and staff base that will continue for the foreseeable future.

SUMMARY OF THE PROGRAM'S GRADUATION REQUIREMENTS

AMERICAN BOARD OF INTERNAL MEDICINE (ABIM) CURRICULUM REQUIREMENTS

REQUIREMENTS FOR CERTIFICATION IN INTERNAL MEDICINE

To become certified in internal medicine, a physician must complete the requisite predoctoral medical education, meet the graduate medical education training requirements, demonstrate clinical competence in the care of patients, meet the licensure and procedural requirements and pass the Certification Examination in Internal Medicine.

Predoctoral Medical Education

Candidates who graduated from medical schools in the United States or Canada must have attended a school that was accredited at the date of graduation by the Liaison Committee on Medical Education (LCME), the Committee for Accreditation of Canadian Medical Schools, or the American Osteopathic Association.

Graduates of international medical schools must have one of the following: (1) a standard certificate from the Educational Commission for Foreign Medical Graduates without expired examination dates; (2) comparable credentials from the Medical Council of Canada; or (3) documentation of training for those candidates who entered graduate medical education training in the United States via the Fifth Pathway, as proposed by the American Medical Association.

Graduate Medical Education

To be admitted to the Certification Examination in Internal Medicine, physicians must have satisfactorily completed, by August 31 of the year of examination, 36 calendar months, including vacation time, of U.S. or Canadian graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada, or the Collège des médecins du Québec. Residency or research experience occurring before completion of the requirements for the MD or DO degree cannot be credited toward the requirements for certification.

The 36 months of accredited internal medicine residency training must be reported at 12 month intervals according to the Clinical Competence Requirement training tables (see below) No credit is granted for unsatisfactory training that requires repetition of a training year at the same level or for administrative work as a chief medical resident. In addition, training as a subspecialty fellow cannot be credited toward fulfilling the internal medicine training requirements.

TRAINING AND PROCEDURAL REQUIREMENTS

MINIMUM MONTHS OF TRAINING	CLINICAL MONTHS REQUIRED	PROCEDURES
36*	30	• Procedures are essential to internal medicine training; to be eligible for certification, all residents must perform procedures during training. • Not all residents need to perform all procedures. • Program directors must attest to general competence in procedures at end of training. • At the completion of training, residents must have demonstrated effective consent discussions, standard or universal precautions, establishment of a sterile field, and application of local anesthetic as applicable to most procedures a resident may perform. • Residents must have the opportunity to develop competence in procedures which will further their development as fellows in their chosen subspecialty or as independent practitioners in their intended fields if entering practice after residency.

** For deficits of less than 35 days 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.*

Content of Training

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 4 of the 30 months may include training in areas related to primary care, such as neurology, dermatology, 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. (See "Leave of Absence and Vacation Policy")

(4) For deficits of 35 days or less 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.

Procedures Required for Internal Medicine

The exposure to the performance of, and the opportunity to develop competence in, invasive procedures by residents is essential for internal medicine residents' preparation for their subsequent subspecialty fellowship or chosen career path.

As of the 2019–2020 academic year, residents must meet the requirements outlined in the table above to be admitted to the Internal Medicine Certification Examination. Internal medicine graduates will likely perform some invasive procedures in the course of their future training or practice; however, the specific procedures will vary based on subsequent subspecialty, hospitalist or general career path taken. The performance of all invasive procedures requires the ability to facilitate an effective discussion with patients regarding risk and benefit of the procedure before obtaining consent, a critical task that all internists must effectively perform. Internists who perform any invasive procedures must be able to initiate a standardized preparation beforehand including hand washing, donning of sterile gloves, preparation of the procedural field, and application of some form of anesthetic. Procedural competence need not be determined solely by a minimum number of successfully completed procedures but may be customized as appropriate through simulation, direct observation, and other criteria determined by the program director and clinical competency committee.

Clinical Competence Requirements

ABIM requires documentation that candidates for certification in internal medicine are competent in: (1) patient care and procedural skills; (2) medical knowledge; (3) practice-based learning and improvement; (4) interpersonal and communication skills; (5) professionalism; and (6) systems-based practice.

Through its tracking process, FasTrack®, ABIM requires verification of candidates' clinical competence from an ABIM certified program director (other ABMS Board and Canadian certification is acceptable, if applicable). See the table on page 3.

In addition, candidates must receive satisfactory ratings in each of the ACGME/ABMS Competencies and the requisite procedures during the final year of required training. It is the candidate's responsibility to arrange for any additional training needed to achieve a satisfactory rating in each component of clinical competence.

As outlined in the table above, all residents must receive satisfactory ratings in overall clinical competence in each year of training. In addition, residents must receive satisfactory ratings in each of the ACGME/ABMS Competencies during the final year of required training. It is the resident's responsibility to arrange for any additional training needed to achieve a satisfactory rating in each component of clinical competence.

PROGRAM DIRECTOR RATINGS OF CLINICAL COMPETENCE

COMPONENTS AND RATINGS	RESIDENTS/FELLOWS: NOT FINAL YEAR OF TRAINING	RESIDENTS/FELLOWS: FINAL YEAR OF TRAINING
Overall Clinical Competence This rating represents the assessment of the resident's development of overall clinical competence during this year of training.		
Satisfactory or Superior	Full credit	Full credit
Conditional on Improvement	Full credit	No credit, must achieve satisfactory rating before receiving credit*
Unsatisfactory	No credit, must repeat year	No credit, must repeat year
Six ACGME/ABMS Competencies** The resident is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in training. They are demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, effective, patient-centered, timely, efficient and equitable care.		
Yes	Full credit	Full credit
Conditional on Improvement	Full credit	No credit, must achieve satisfactory rating before receiving credit*
No	Full credit	No credit, must repeat year

** At the discretion of the program director, training may be extended so that the resident or fellow can attain satisfactory competence in overall clinical competence and/or the six ACGME/ABMS Competencies.*

*** The six ACGME/ABMS Competencies are: (1) patient care and procedural skills, (2) medical knowledge, (3) practice-based learning and improvement, (4) interpersonal and communication skills, (5) professionalism and (6) systems-based practice.*

Source Material: https://www.abim.org/Media/splbmcpe/policies-and-procedures.pdf

American Board of Internal Medicine®

MARCH 2024

POLICIES & PROCEDURES FOR CERTIFICATION

PROGRAM LISTING OF REQUIRED PROCEDURES

The program expects all residents be aware of the indications for and the delivery of the listed procedures. Proficiency of their completion and documentation of this in New Innovations will be tracked throughout your training.

Knowledge competence includes knowing and understanding the following for each procedure:

Indications	Contraindications
Recognition and Management of Complications	Pain Management
Appropriate Use of Sterile Technique	Specimen Handling
Interpretation of Results	Aspects of Obtaining and Knowledge of Informed Consent

All procedures must be logged into New Innovations. If a resident desires to obtain performance competence in a procedure that is not required, he/she should notify the program director so the appropriate learning experience can be arranged. Before residents can supervise or teach any procedures, required or optional, to other residents or interns, the supervising resident must have successfully performed and completed the requisite number of the corresponding procedure as listed in the table below. Only after then will they be deemed competent to perform the procedure independently after obtaining approval from their supervising attending and consent from the patient. Observation and simulation of any procedure is not sufficient for the consideration of competency to perform the procedure. We would encourage residents to continue logging procedures even after the minimum numbers of procedures is met for graduation as this is useful for post-residency credentialing and hospital privileges.

Competency is required in the following procedures:

	Know, Understand and Explain				**Perform Safely and Competently**	
	Indications; Contraindications; Recognition & Management of Complications. Pain Management; Sterile Techniques	**Specimen Handling**	**Interpretation of Results**	**Requirements & Knowledge to Obtain Informed Consent**		**Number Needed to be deemed "competent"**
Abdominal paracentesis	X	X	X	X	X	5
Advanced cardiac life support	X	N/A	N/A	N/A	X	3

Competency is required in the following procedures:

	Know, Understand and Explain				Perform Safely and Competently	
	Indications; Contraindications; Recognition & Management of Complications. Pain Management; Sterile Techniques	**Specimen Handling**	**Interpretation of Results**	**Requirements & Knowledge to Obtain Informed Consent**		**Number Needed to be deemed "competent"**
Arterial line placement	X	N/A	X	X	X	5
Arthrocentesis	X	X	X	X	X	3
Central venous line placement	X	X	N/A	X	X	5
Drawing venous blood	X	X	X	N/A	X	3
Drawing arterial blood	X	X	X	X	X	3
Electrocardiogram	X	N/A	X	N/A	X	N/A
Incision and drainage of an abscess	X	X	X	X	X	3
Lumbar puncture	X	X	X	X	X	5
Nasogastric intubation	X	X	X	X	X	3
Pap smear and endocervical culture	X	X	X	X	X	5
Placing a peripheral venous line	X	N/A	N/A	N/A	X	3
Pulmonary artery catheter placement	X	N/A	X	X	N/A	N/A
Thoracentesis	X	X	X	X	X	5

PROGRAM DESCRIPTION OF ROTATIONS

Direct Patient Care Months	Additional IM Rotations	Non-Medicine Electives
Ambulatory General Medicine Cardiology Critical Care Emergency Medicine Gastroenterology Global Health Hematology/Oncology Hospital Medicine Infectious Disease Nephrology Night Medicine (Night Float) Pulmonology	Endocrinology Gynecology Neurology Palliative Care Point of Care Ultrasound Psychiatry Rheumatology Sports Medicine Teaching Resident	Radiology Research Surgical Critical Care

ACGME INTERNAL MEDICINE RESIDENCY REVIEW COMMITTEE (RRC) CURRICULUM REQUIREMENTS

Full versions of the latest accreditation requirements can be found at: https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements

CURRENT CURRICULUM BLOCK DIAGRAM

PGY - 1	8 – 9 Hospital Medicine Blocks 4 Critical Care Blocks 4 Night Medicine Blocks 2 Emergency Medicine Blocks 1 Subspecialty Block[+]
PGY-2	7 – 8 Subspecialty/Elective Blocks[+] 4 Hospital Medicine Blocks* 4 Critical Care Blocks* 3 – 4 Cardiology Blocks 1 – 2 Night Medicine Blocks* 1 VAMC Primary Care Block
PGY-3	9 – 10 Subspecialty/Elective Blocks[+] 4 Hospital Medicine Blocks* 4 Critical Care Blocks* 2 Cardiology Blocks 1 Night Medicine Block* 1 VAMC Primary Care Block

The program utilizes a 4 + 1 scheduling model. Residents have 4 weeks of an inpatient or elective rotation followed by 1 week of ambulatory medicine where their longitudinal continuity clinic experience is also conducted. A block has a duration of at least 2 calendar weeks. To receive credit for a rotation the resident must attend 80% of scheduled activities.

*Supervisory role during rotation.

[+]All residents must complete at least one block of ID, nephrology, GI, Psychiatry, Geriatrics/Palliative Care, and Point of Care Ultrasound prior to graduation. Residents may ask to have more time on these electives.

PROGRAM STANDARDS

Successful progress through the ACGME/ABIM Milestones as determined by the **Clinical Competency Committee -** www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/InternalMedicineMilestones.pdf.

- Demonstration of competence in all core competencies on monthly and semi-annual evaluations.
    a. Unsatisfactory/Marginal performance on evaluations may require repeating a rotation at the discretion of the program director and/or the clinical competency committee.
- Direct observations in both inpatient and outpatient settings.
    a. Interns: 2 outpatient and 2 inpatient evaluations completed by December 31.
    b. Residents: 1 outpatient and 1 inpatient evaluation completed by March 30.
    c. Handover: 1 per year completed by March 30.
- Completion of the resident scholarly activity requirement.
- A passing score on USMLE Step 3 is required before promotion to PGY2. Residents must be registered to take the exam by February 28 of PGY-1 year to have results back in time for promotion by July 1. Failure to pass USMLE Step 3 before the end of the 1st year may be grounds for non-reappointment or dismissal from the program.
- Every resident must evaluate each rotation, attending, assigned peers, and the program. These evaluations must be completed within 14 days of the completion of the activity.
- Residents must maintain an active (and in no way let it expire or lapse) ACLS certification during all 3 years of residency. Failure to maintain this certification may cause removal from duty until the ACLS certification is again deemed active which could prolong training or result in the forfeiture of pay for any time away from work.
- Attendance at scheduled conferences is expected. Failure to meet a minimum of 75% attendance will result in referral to the clinical competency committee.
- You are required to contact your supervising attending and the chief resident (or their assigned designee) concerning all absences from rotations.
- All schedule changes and/or requests must go through the chief resident and be approved by the program director.
- Completion of all program assignments as assigned and directed by the program director.
- Completion of patient medical and program records are a required milestone and competency that will be tracked and is required and expected from all residents. Medical records and compliance logs are an intricate part of patient care. Our program expects residents to meet deadlines and meet all our expectations concerning their completion.

a. Daily Inpatient Progress Notes: As dictated by assigned service. Generally, should be complete by 2 - 3 PM.

b. Outpatient Progress Notes: Notes should be completed before the end of the clinic session. All notes must be finalized within 24 hours of seeing the patient.

c. Inpatient Discharge Summaries: Ideally these documents should be completed at the time of discharge but must be completed no later than 24 hours from the patient's departure from the hospital.

d. Duty Hour Logging: No more than 6 days should expire without logging duty hours.

e. Email: You will be contacted through email for many things, and we expect you to check email daily when you are assigned for duty. We will only use your Erlanger issued email and expect that you use it for all residency/work related items.

- Active participation and completion of required mentorship program tasks.
- Adherence to all college and health system policies regarding professionalism, dress, patient privacy, and communication standards.

MENTORSHIP PROGRAM

The program utilizes an active and dynamic mentorship model. Our goal is that each resident's mentor(s) will provide ongoing and active assistance in the resident's longitudinal development with the end goal being the accomplishment of personal and career goals while ensuring progression along the program requirements for graduation.

Every resident will be assigned a primary mentor. Mentorship pairing is initially set based on the program leadership's assessment of fit, academic interest, and compatibility amongst faculty volunteers with training and interest in mentorship. Assignments can be changed with communication between the mentee-mentor and program leadership. Secondary mentors can also be identified to aid in resident development.

Formal mentorship meetings should occur regularly but are designed at a minimum to occur quarterly. We have developed a form/tool to document these meetings which then can be subsequently reviewed by the program leadership and the clinical competency committee.

Informal mentorship activities are encouraged but not mandated by the residency program. Opportunities for scholarly collaboration, wellness promotion, planning for study and board exam preparation, career planning, etc. are pursued based on the interest and initiative of the mentee-mentor pair.

SCHOLARLY ACTIVITY

The University of Tennessee College of Medicine Chattanooga Internal Medicine Program provides an ample platform for residents to comply with the ACGME requirements for scholarly activity (Table 1).

Our program promotes and nurtures resident scholarly activity with the following objectives in mind:

- Train the next generation of clinical investigators and physician-scientists
- Promote intellectual and academic curiosity
- Support academic subspecialty fellowship applications
- Lay the foundation for successful careers in general and academic medicine

Internists should be not only familiar with evidence-based medicine and the foundations of research from bench to the bedside but are encouraged to participate in research while in residency as the academic structure of the college provides the needed resources for the learner to successfully engage in these activities. Residents should refer to Table 2 for additional details relative to research.

Completion of this requirement is mandatory without exceptions. Residents are responsible for providing to the program coordinator a copy of all abstracts, manuscripts, workshop handouts, etc. for which the resident desires credit for the scholarly activity requirement in a timely manner (within 30 days of completion or acceptance of the activity). All activities must comply with institutional IRB requirements and all projects must be overseen by a faculty mentor.

The current and applicable requirement for scholarly activity of all residents as of February 5, 2019, states: All residents must complete a rigorous Quality and Safety curriculum with projects in the second and third year and must do one of the following during their residency:

Option 1: Manuscript or Book Chapter Publication

Option 2: Presentation at a National, Regional or State Meeting (Original Research or Clinical Vignette)

Option 3: Local Workshop Presentation approved by PD and Mentor ***OR*** Grand Rounds Presentation

Successful documentation of completion of one of the above options is mandatory for successful completion of residency and ability to sit for credentialing examinations.

TABLE 1: ACGME INTERNAL MEDICINE RRC REQUIREMENTS FOR SCHOLARLY ACTIVITY

RRC IM Standard
IV.D. Scholarship Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching. The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship. **IV.D.1. Program Responsibilities** IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core) IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core) IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core) Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care. Internal Medicine Elements of a scholarly approach to patient care include: • Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan • Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature

• When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)

• Improving resident learning by encouraging them to teach using a scholarly approach

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

IV.D.3. Resident Scholarly Activity

IV.D.3.a) Residents must participate in scholarship. (Core)

IV.D.3.a). (1) A program's graduates must demonstrate dissemination of scholarship within or external to the program by any of the following methods: (Core)

IV.D.3.a).(1).(a) presenting in grand rounds, poster sessions, leading conference presentations (journal club, morbidity and mortality, case conferences); workshops; quality improvement presentations; podium presentations; grant leadership; non-peer reviewed print/electronic resources; articles or publications; book chapters; textbooks; webinars; service on professional committees; or serving as a journal reviewer, journal editorial board member, or editor. (Core)

TABLE 2: RESEARCH PRIMER

Goals and Objectives	The research component of resident training is aimed to establish competency in the design, conduct, interpretation, and presentation of research by encouraging the resident to complete at least one major project and to participate in additional projects, time permitting. The expected benefit of secondary projects includes the opportunity to enlarge upon previous research and topics, the opportunity for co-resident mentorship, and opportunities for additional authorships. The research experience is based on a mentorship model where the resident and faculty research mentor will collaborate to develop and execute a research project. Selection of clinical research projects follows a similar protocol; that is, the resident research interest should match with the appropriate faculty mentor.
Available Study Designs	***Prospective Clinical Studies:*** Studies in which data is collected prospectively whether a clinical trial or a prospective observational study. As such studies take a significant amount of time in data collection; residents are encouraged to identify a research topic and faculty mentor very early, preferably within few months of starting residency. ***Retrospective Clinical Studies:*** In these studies, data has already been collected, generally during clinical encounters. Depending on the study question, these studies can

	take a significant amount of time as often data needs to be pulled from medical records. Ideally, these studies should be started within the first year of residency. Residents are strongly encouraged to identify mentors (seek help from PD or APD if you have difficulty in identifying mentors) during the first year of residency. ***Meta-analysis and Systematic Reviews:*** These studies summarize results from published literature and build evidence-base that can be ultimately used for developing guidelines. Often, a team of two or more investigators is needed and literature review and analysis may take up to a year. Residents interested in working on a meta-analysis/systematic review should start working on it during the latter part of the first year or early part of the second year of residency. ***Secondary Data Analysis:*** Residents who are comfortable with statistical analysis or who want to learn statistical analysis may want to analyze publicly available dataset for their question. Several datasets are available including NHANES, CHANES, and CMS datasets from Hospital Compare website. Residents should start their project during the latter part of the first year or early part of the second year of residency.

All research conducted and case reports prepared by a resident must meet IRB standards. Case reports and vignettes should also follow applicable institutional policies including the completion of form H.

LONGITUDINAL QUALITY IMPROVEMENT CURRICULUM

The department and the residency program will align with both the University of Tennessee College of Medicine Chattanooga and Erlanger Health System in their quality missions and in doing so will meet accreditation standards for quality and patient safety as outlined by the RRC for Internal Medicine. The chair and a designated departmental quality officer will work with program leadership in the design, implementation, and execution of a longitudinal quality and patient safety curriculum. All residents should expect to attend scheduled Patient Safety Conferences and/or Mortality & Morbidity conferences that are scheduled during the noon conference series as well.

Educational Requirements:

- PGY-1:
  - Demonstrate ability to enter a patient safety concern or event into the reporting system as an “e-safe”.
- PGY-2:
  - Lead and present a morbidity and mortality conference.
  - Participate in a patient safety or quality improvement committee.
- PGY-3:
  - Present at QIPS Day.

Quality Improvement Project: All residents must complete a quality improvement project at some point during their residency. The program encourages this to be done in the first and/or second year of residency. The project must comply with standards set forth by the program and the GME office. All projects must have an

identified faculty mentor from start to finish and should be submitted to the IRB for approval so any collected data can be presented in an oral or print presentation. Residents may choose to work individually on this project or can work in groups. The project should be of enough substance so that is eligible for presentation at a local, regional, or national meeting.

RESIDENT CLINICAL EXPERIENCE AND EDUCATIONAL WORK HOURS (DUTY HOURS)

ACGME REQUIREMENTS FOR CLINICAL EXPERIENCE AND EDUCATIONAL WORK HOURS

- Residents may not work more than 80 hours a week, when averaged over 4 weeks (includes moonlighting hours).
- Residents must have 1 day off in 7, when averaged over 4 weeks.
- Residents should have at least 10 hours off between duty assignments.
- Residents may not work more than 24 hours/shift, plus may spend up to an additional 4 hours to ensure an appropriate, effective, and safe transition of care and maintain continuity of care.

The department strictly adheres to and monitors work hour compliance. Please enter hours in the New Innovations (NI) Duty Hours Module daily. The GME Office requires that residents update work hours reporting at least every 7 days. Those who fail to update work hours every 7 days are not in compliance with GME Institutional Policy which is monitored by the GME Office and can be subject to disciplinary action.

NEW INNOVATIONS

Hours you are in the hospital during most days should be logged as “Regular Duty”.

Only 24 hours shifts should be designated as “Call”. All else should be entered into the system as regular duty.

Duty Hour Types:

a. Regular – the majority of shifts will be entered in NI as regular duty.
b. Call – a 24-hour in-house overnight shift. **This should not exist at this time for our program**.
c. Post Call – begins after the 24-hour in-hospital overnight call and is limited to 4 hours to complete handover and patient care. This must be logged separately. This should not exist at this time for our program.
d. Night Float/Night Medicine
e. Moonlighting
f. Vacation/Leave – vacation, personal days, or sick days.
g. Regular “off” days from a rotation do not need to be logged.
h. Exceptional Circumstances – Residents can stay over at the end of an assigned shift to care for an end-of-life patient and their family or participate in a rare or unusual educational opportunity.

Explanation/justification must be entered by the resident and must be reviewed and approved by the Program Director or his or her designee.

i. Work from Home – Residents can log the patient care time they spend working at home, such as charting or taking phone calls. This does not include studying, reading, or other scholarly activity such as research and personal work on presentations.

All hours logged that create a duty hour exception in New Innovations require the resident to document in the comment section an explanation documenting why the exception occurred. Residents not doing so will be instructed to do so by program leadership.

SUPERVISION

The Department of Internal Medicine will ensure that all patient care is supervised by qualified faculty. Faculty schedules will be structured to provide residents with continuous supervision and consultation. Attending supervision should be adequate to provide quality patient care, and at times will require the daily examination and evaluation of the patient. At other times, this supervision may be accomplished by discussion during teaching rounds. A resident may request the physical presence of an attending at any time and is never to be refused. Attendings will be available for immediate consultation by pager/phone 24 hours a day.

Refer to the following definitions for physicians providing supervision:

- **Attending of Record**: Faculty member responsible for the service to which a patient is assigned.
- **Supervising Physician**: Attending or upper-level resident who is directly or indirectly supervising the patient care activities of interns.

Refer to the following definitions for supervision which provides graduated authority and responsibility:

- **Direct Supervision**: Supervising physician is physically present with the resident and patient.
- **Indirect Supervision (with direct supervision immediately available)**: Supervising physician is physically within the hospital or other site of patient care and is *immediately* available to provide direct supervision.
- **Indirect Supervision (with direct supervision available)**: Supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by phone/text, and can be on site expediently to provide direct supervision if needed.
- **Oversight**: Supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Duties that require a verbal discussion may be performed but should be discussed prior with the supervising physician, except in the case of an emergency. The supervising physician will then decide if the resident should perform this duty with indirect or direct supervision. The ultimate decision always rests with the attending of record or on-call attending physician.

Duties that require direct supervision are performed with the supervising physician present with the patient.

INTERN SUPERVISION REQUIREMENTS

	Indirect supervision with direct *immediately* available	Direct Supervision
Patient Care	Evaluate unstable patients Perform a history and physical Order routine medications Order diagnostic tests	Administration of an anti-arrhythmic Make a DNR order Resuscitation from shock Transfer a patient to the ICU Ventilator management
Procedures	Intravenous line placement Nasogastric tube placement Pap smear and endocervical culture Urinary catheter placement Venous blood draw	Incision and drainage of abscess Arterial blood draw Arterial line placement Arthrocentesis Bone marrow biopsy Central venous line placement Endoscopy Endotracheal intubation Lumbar puncture Paracentesis Pulmonary artery catheter placement Thoracentesis

All interns are required to be certified in Advanced Cardiac Life Support (ACLS) and should perform all procedures required regardless of if the supervising physician is present in emergent situations. When an intern is working, an upper-level resident or attending physician must be physically present in the same building.

Interns are expected to contact the supervising physician (either upper-level resident or attending) in the following circumstances:

1. Significant change in patient condition:
    - Transfer of the patient to the intensive care unit
    - Need for intubation or ventilator support
    - Cardiac arrest or significant changes in hemodynamic status
    - Development of significant neurological changes
    - Development of major wound complications
    - Any significant clinical problem that will require an invasive procedure or operation
    - Change in code status (upper level and attending should be notified)

2. Patient death (expected or unexpected).

3. Treatment error or complication.

4. New patient admission to the hospital or patient transfer from another facility --

a. Stable Patients: Interns should notify their supervisory physician at the earliest time convenient that does not interfere with his/her patient care duties.

b. Unstable Patients: If after preliminary evaluation and assessment an unstable patient is identified, the supervising physician should be notified immediately (guideline of 5 minutes).

5. Patient requesting to leave the hospital against medical advice (AMA).

6. Patient or family request for a discussion with supervising physician.

UPPER-LEVEL RESIDENT SUPERVISION REQUIREMENTS

	Oversight	Indirect supervision with direct available (verbal discussion)	Direct supervision
Patient Care	Evaluate unstable patients Perform a history and physical Order medications Order diagnostic tests	Administration of an anti-arrhythmic Resuscitation from shock Ventilator management Make a DNR order	
Procedures	Arterial blood draw Incision and drainage of abscess Intravenous line placement Nasogastric tube placement Pap smear/endocervical culture Urinary catheter placement Venous blood draw	Arterial line placement Arthrocentesis Central venous line placement Lumbar puncture Paracentesis Thoracentesis	Bone marrow biopsy Endoscopy Endotracheal intubation PA catheter placement

Upper-level residents should be always available to the intern on service and in their absence will assume all primary caregiver responsibilities. Upper-level residents are directly responsible to the attending of record, and should maintain open, continuous lines of communication regarding the status of the patients on the teaching team. On services with upper levels and fellows, residents are responsible to the fellow and attending on the service. As residents progress through upper-level months, increasing responsibility and autonomy are provided by the attending on service, such that by the final inpatient months of training, each resident should essentially be functioning as an attending with regards to medical decision-making.

In the setting of an intern being supervised by an upper-level resident, it is expected that the supervising resident examine and evaluate each patient on the service at least daily. The upper-level resident and intern should maintain clear communication about the patient's care.

Upper-level residents are expected to contact the attending of record or on-call attending in the following circumstances:

1. Significant change in patient condition:

- Transfer of the patient to the intensive care unit
- Need for intubation or ventilator support
- Cardiac arrest or significant changes in hemodynamic status
- Any significant clinical problem that will require an invasive procedure or operation

2. Patient death (expected or unexpected).

3. Treatment error or complication.

4. New patient admission to the hospital or patient transfer from another facility:
   - Stable Patients: Upper-level residents should contact the attending of record or on-call attending after their initial evaluation is complete and at the earliest time convenient that does not interfere with his/her patient care duties.
   - Unstable Patients: If after evaluation and assessment an unstable patient is identified, the attending of record or on-call attending should be notified promptly (guideline of 15 minutes) by one of the team members, unless all team members are needed to stabilize the patient's condition or coordinate transfer to the ICU. If such a delay is required than a call should be placed as soon as feasible.

5. Patient requesting to leave the hospital against medical advice (AMA).

6. Patient or family request for a discussion with supervising physician.

7. Same day admissions and discharges should be discussed at the time of discharge.

AMBULATORY SUPERVISION OF ALL RESIDENTS

In clinic, both interns and upper-level residents serve as the primary caregivers to each patient and are immediately responsible to the attending. Each resident has an increasing degree of responsibility commensurate with his/her level of training. It is important to remember that, while the training program emphasizes resident responsibility for patient care as a principle of learning, the physician who is legally responsible for what happens to a patient is the attending physician of record.

Each patient evaluated by a resident in the University Medical Associates practice has a member of the medical staff as his/her attending physician who is physically present and readily available during the entire clinical encounter. Residents will perform a history and physical examination on the patient and review these findings with the supervising attending physician. The resident will develop an assessment and plan for the patient, and this will be discussed with the supervising attending. Interns in their first 6 months of residency will review the plan of care with the patient in the physical presence of the attending physician. After successful completion of the first 6 months of residency, the attending physician will decide which patients he/she must physically see prior to discharge from clinic. Residents will generate a problem-based note summarizing the history, physical examination, assessment, and plan for the patient. Each note will be reviewed and signed by the supervising

attending. Residents will provide continuity of care for their patients with the guidance of the supervising attending.

FATIGUE MITIGATION & ALERTNESS MANAGEMENT

Every resident receives formal training and education on recognizing the signs of fatigue and sleep deprivation. If at any time a resident feels they that are fatigued or sleep-deprived and therefore cannot perform their patient care responsibilities, they are to immediately notify their supervising physician (always including the attending physician of record). The attending will then relieve the resident of patient care responsibilities and help the resident to arrange transportation home. The resident will also notify the chief resident and program director of their status. The chief resident will utilize the backup coverage system as needed to provide additional resident coverage for patient care responsibilities. It is the program's expectation when this system is engaged that the attending of record physically return to the patient care team and direct management of all patient care activities until a full complement of resident members is again available for the appropriate amount of patient care.

Strategic napping is encouraged when necessary and residents have available space in the handover room and assigned call rooms to do so. If residents are unable to perform their clinical duties and require strategic napping, they are to immediately inform the attending physician of record who will replace them on a patient care team until another resident can be pulled from the systems as described above.

TRANSITIONS OF CARE (HANDOFF) POLICY

All inpatient handoffs will be face to face unless an extraordinary event requires a verbal checkout using a phone. Handoff sessions using the I-PASS tool must occur any time there is a change of resident(s) caring for a patient. Examples include outgoing daytime shifts signing out to an overnight shift, overnight shift residents signing out to residents on a daytime shift, or a resident with a day off signing out to the co-resident. The program ensures that housestaff are competent in communicating with team members in the handoff process by direct observation of interns by supervising residents or faculty.

Procedure for Handoff

1. The outgoing house staff member reviews the patient information in the EMR. He/she is responsible for reviewing and updating pertinent information relation to diagnoses, procedures, and items that need to be done with any clarifying comments.
2. A designated time and place are set for the handoff. For some services, a preset time and place for the house staff handoff will be established by the program. Others will need to establish a time and place depending upon daily schedules. Regardless, accurate communication requires the following elements be established:
    a. A time window during which non-urgent calls can be delayed and coverage for urgent issues established to provide an uninterrupted opportunity to transition patient care.
    b. A location in a confidential, quiet area with ready computer access.

3. The incoming and outgoing house staff should meet face-to-face with the handoff tool immediately available on the computer. During the dynamic handoff, any misinformation noted on the handoff tool should be immediately corrected.

4. The outgoing house staff should verbally hand over each individual patient, providing the following elements for each individual patient:

    a. Clear identification of the patient by full name and birth date

    b. Statement of the patient's code status

    c. Summary statement(s) of the pertinent elements of the hospital stay

    d. List of essential active issues which the incoming physician may need to be address

    e. List of contingency plans, including anticipated issues and suggested remedies for the individual patient

    f. List of follow-up activities, including any tests, procedures, or therapeutics which the incoming physician may need to evaluate

EVALUATION

ROTATION GOALS, OBJECTIVES, AND ASSESSMENTS

The goals and objectives for each rotation are available in New Innovations and should be reviewed prior to the beginning of a rotation. The attending is to verbally provide feedback to team members at a minimum of half-way through the rotation and at the end of the rotation; this is in addition to completing the final written evaluation (within the electronic evaluation system).

Throughout residency training, all residents will receive feedback from multiple evaluators, including but not limited to, attending physicians, peers (fellow and resident), students, ancillary staff, and patients. These evaluations will be available though some may be batched to protect anonymity. Likewise, residents are responsible for providing feedback to students, peers, and supervisors. All evaluations of peers, supervising attendings, and rotations are confidential after submission. All identifying information is removed and evaluations are compiled and released in batches to ensure anonymity. The Department of Internal Medicine expects all evaluators to complete evaluations within two weeks of rotation completion. Feedback should be provided in a constructive professional manner.

PROGRAM DIRECTOR SEMIANNUAL EVALUATION

Every resident will meet with the Internal Medicine Program Director or Associate Program Director twice yearly. These meetings are intended to summarize all relevant performance data, create an individualized learning plan for each resident and provide mentorship in career development. In preparation, residents should review their evaluations from all sources and complete any assigned preparation activities.

CLINICAL COMPETENCY AND RESIDENCY QUALITY IMPROVEMENT COMMITTEE (CCC)

The Internal Medicine Program Director is primarily responsible for monitoring resident progress and promotion decisions. The Clinical Competence Committee (CCC) for the Internal Medicine Residency Program is advisory to the Program Director and assists the program director in these functions. At all times, the procedures, and policies of the CCC will comply with those of the Graduate Medical Education Committee.

Faculty members are appointed by the Program Director and must be deemed "core faculty". The committee is composed of the Associate Program Directors, a representative body of core faculty, and the chief resident. Where circumstances warrant, the membership of the committee may be altered to avoid a potential conflict of interest, or to protect the privacy of the resident. The Internal Medicine Residency Program Director will attend the meetings, report on findings, but will be an ad hoc member without an ability to vote on any procedural decisions. A core faculty member will chair the CCC.

The CCC meets at a minimum of twice per year to conduct semi-annual summary performance reviews. The CCC will also convene anytime a resident is referred for noncompliance with residency requirements. A resident may be brought before the CCC for failure to complete any of the residency requirements, including but not limited to failure of any clinical rotation, insufficient progress on evaluations (in any domain), or unprofessional behavior in any venue.

Semiannual reviews will consist of an assessment of progression toward competence determined through a multi-source assessment of each resident. This assessment will be based on the Internal Medicine Milestones as determined by the joint ABIM/ACGME committee in addition to a more general assessment of progression in the ACGME general competencies of medical knowledge, patient care, practice-based learning and improvement, communication, and interpersonal skills, professionalism, and systems-based practice. Residents will be evaluated on individual rotation requirements, program policies, and institutional policies. The individual components of the CCC assessment include but are not limited to the following:

Medical Knowledge

- Global Faculty Evaluations
- Progression with independent learning and scholarly activities
- Conference attendance
- Progression with Directed Reading

Patient Care

- Global Faculty Evaluations
- Direct Observations
- Procedure Logs

Practice-Based Learning & Improvement

- Global Faculty Evaluations
- Progression with independent learning and scholarly activities
- Involvement and leadership with quality improvement projects

Communication & Interpersonal Skills

- Global Faculty Evaluations
- Multisource Evaluations (Peer, Staff, Patient)
- Direct Observations

Professionalism

- Global Faculty Evaluations
- Multisource Evaluations (Peer, Staff, Patient)
- Direct Observations
- Compliance with duty hours logging
- Compliance with medical records policies
- Conference attendance

Systems-Based Practice

- Global Faculty Evaluations
- Multisource Evaluations (Peer, Staff, Patient)
- Involvement and leadership in quality improvement projects

Each semiannual review will produce a written summary of the resident's progress in meeting ABIM/ACGME Milestones and program requirements. The summaries will be provided to the Internal Medicine Residency Program Director to assist in the completion of ABIM/ACGME Milestone progress. If upon review of a resident file the CCC feels 'action' is necessary, the resident will be asked to address the committee to discuss the issue in detail. After discussion and deliberation, the CCC can address the issue with a notice of concern, probation, suspension, or immediate dismissal. Actions that may adversely impact on health or safety of patients or others are addressed by Probation, Suspension and/or Immediate Dismissal.

The house officer will be notified of any formal decision (Probation, Suspension, Immediate Dismissal) as soon as circumstances reasonably allow, and in most cases four months prior to the end of the contract year. Exceptions to this timeframe would include performance issues that primarily arise within the final four months of the contract year. If a house officer is on probation, and the end of the house officer's probation period is within four months of the end of the contract year, the fact that the house officer is on probation will serve as notice that the house officer may not be promoted if the probation is not remediated successfully.

The training program must provide evaluation and assessment information to residents in a continuous manner throughout the year. In addition, the training program must provide written summary performance reviews to residents at least semi-annually, in person. A review of the resident's experience and competence in performing clinical procedures must be included in these summaries. A review of the resident's progress in meeting ABIM and program requirements must also be performed at this time. Summary performance reviews may be written by program directors, designated faculty members, or members of the CCC. It is also recommended that the resident acknowledge receipt of each summary performance review in writing as detailed in Appendix I.

CRITERIA FOR PROMOTION

Promotion to each subsequent year of training requires demonstrating competence that meets expectations on the specific learning objectives of the evaluations across all clinical rotations during that year of training.

Residents failing to meet this standard will be reviewed by the CCC which may elect to withhold promotions and remediate or promote with an accompanying remediation plan.

IN-TRAINING EXAMINATION

The Department of Internal Medicine provides the opportunity for every resident to take the ACP in-training examination (ITE) annually. Arrangements will be made for residents on services with significant patient workload to take the ITE while their service is covered by other resident(s) or attending(s). Satisfactory performance on the yearly ITE is expected of all residents, defined by achieving a score of at least the 30th percentile for residents at a comparable level of training. Residents not achieving satisfactory performance will meet with the Program Director or Associate Program Director to discuss performance improvement strategies. Residents scoring below the 30th percentile will be excluded from all moonlighting activities.

INDEPENDENT LEARNING ACTIVITIES

One of the core goals of the residency training program is to equip residents with the medical knowledge needed to successfully pass the Internal Medicine certification examination. We have provided residents with an educational curriculum and foundation that will ensure passage of the board exam. At its heart, the curriculum includes elements of independent learning activities in addition to attendance of didactic conferences. The residency understands that certain residents may have learning styles that favor certain types of independent learning activities. However, all the learning activities provide modalities that are effective in preparing for board examinations.

INDEPENDENT LEARNING

All residents will be required to do sixty 75 independent study questions per month using MKSAP.

Residents scoring less than the 30th percentile on the ACP In-Training Examination will be assigned additional activities by program leadership and will be placed on a performance improvement plan (PIP) for medical knowledge to facilitate resource allocation and sustained monitoring/help for the resident's benefit. 300 – 600 additional MKSAP questions will be included as part of the PIP.

Program leadership will track completion of MKSAP questions.

Compliance with changes in the program are appreciated and expected. Throughout the year the program may change or restructure the program to ensure the optimal education environment and individual retention is achieved.

REAPPOINTMENT, PROMOTION, NON-RENEWAL, AND APPEALS POLICIES

The Department of Medicine follows the University of Tennessee College Of Medicine Chattanooga Graduate Medical Education Programs Institutional Policy on Resident Re-Appointment, Promotion, and Non-Renewal and Appeals which can be found on the college website.

INTERNAL MEDICINE DEPARTMENT LEAVE POLICY

Per UT Policy, a UT Resident Time off Sheet must be submitted and signed each month to report all leave, regardless of whether the resident has taken time off for that period.

Residents must notify their supervising attending and the department (program coordinator and chief resident) of any leave time including sick days, personal days, etc. prior to an absence from a rotation.

The ABIM requires all internal medicine trainees to complete 33 months of training to be eligible for the medicine board exam; thus, cumulative leave of more than 3 months (thirteen weeks) for any reason will extend the period of training beyond the traditional 36 months.

Internal Medicine residents are allowed:

- Three weeks (15 working days) of vacation leave per academic year.
- Four personal days per year that do not roll forward if not used.
    - Personal days should not be taken on required subspecialty electives.
    - Personal days should not be taken on the Friday preceding a vacation or the Monday following a scheduled vacation.
    - Residents taking a personal day while scheduled on jeopardy/back-up need to either find coverage, and are still responsible for working that day if called into work if no such coverage is arranged.
    - One week of Continuing Medical Education each academic year.

Reminder for PGY3s: Your appointment ends end June 30th, if you plan to leave prior to June 30th please make sure you have sufficient vacation time.

✓ **Unexpected Absences**

The resident must provide a medical provider's statement for the period of any sick leave, submitted within one week to the program coordinator's office. The provider must not be a trainee (co-resident) or any faculty member of the Department of Internal Medicine aside from an identified PCP. Examples of acceptable documentation include an APP working in an Urgent Care Clinic, an ED provider, or the resident's PCP. Failure to provide this documentation will require payback of the shift covered by the backup resident, arranged by the Chief Resident.

✓ **Vacation Leave**

All vacation requests for the entire academic year should be received by the program coordinator no later than July 15. The program understands that things will come up during the year and we will work with residents on an individual basis as well. Unrequested vacation not submitted prior to the 15th must be taken on an ambulatory week. Permission for use of leave during electives is rare with the resident requiring approval from the rotation's supervising attending, the chief resident, and the program director.

Residents MAY NOT schedule vacations during Hospital Medicine, Night Medicine, Critical Care, Cardiology, or Emergency Medicine.

Additional Items of Emphasis:

a. Unused vacation leave cannot be utilized in a subsequent academic year.

b. No more than 1 resident on the same rotation can be scheduled off unless special approval is granted.

c. Vacation leave is granted on a first come, first-approved policy.

d. Vacation leave is assigned in one-week intervals at a minimum (5 business days/7 calendar days).

e. For overseas travel, residents must understand the risk of travel delays and the potential for lengthening the residency duration required to meet ABIM training requirements. If a resident is delayed by more than 60 days from returning to his/her residency assignments because of travel outside of the US, his/her status as a resident in the Internal Medicine Residency may be terminated.

✓ **Extended Vacation Leave**

- Maximum of 3 weeks consecutively but resident must have sufficient unused vacation time for that academic year.

- Please request extended leave as soon as possible. Ideally you should submit your leave requests prior to July 1 of the academic year for which the leave is being requested.

✓ **Leave for Presentations at State and National Meetings**

Approval is contingent on the ability to provide adequate patient care coverage as well as academic considerations. An arrangement for the appropriate continuation of patient care duties in his/her absence is the responsibility of the presenting resident and must be approved by the chief resident. If approved, the Department of Medicine will provide residents with reimbursement according to departmental guidelines for presentations at state or national meetings if funding is available through the institution. If the institution is devoid of funding, we cannot provide any coverage of costs incurred by the resident to present. No more than one regional or national meeting will be funded (if funds available) during each academic year for a resident to present accepted submissions; however, residents may apply their own unused CME (Continuing Medical Education) funds to attend additional meetings. Requests for funding the presentation of a completed resident Research project which has been accepted for presentation at a regional or national meeting after a resident has already received departmental funding for a regional and a national meeting during that academic year will be evaluated individually. Residents on a Performance Improvement Plan (PIP) or on Probation will not be granted leave from rotations for presentations.

✓ **Leave for Interview Dates**

The Residency Program understands that invitations for fellowship interviews often occur with little advanced notice and offer only a single or limited number of days to interview. Employment interviewing typically offers more flexible scheduling. As soon as an invitation for an interview is received, the resident must contact the chief resident and supervising attending. Residents should have sufficient vacation and/or personal days available for the expected dates of leave if they are not using their allotted days off for that rotation OR arrange

coverage with other residents so that no patient care duties of any kind by either party are compromised. A signed leave form must be returned to the Program Coordinator prior to the absence. The resident is responsible for arranging coverage for patient care during his/her absence.

✓ **Sick Leave**

Residents are allowed up to 3 weeks (with one weekend for each sick week taken) paid sick leave days per year, if needed.

Residents should be advised that sick days are not carried over from year to year.

All residents must provide a medical provider's statement for the period of any sick leave, submitted within one week to the program coordinator's office. The provider must not be a trainee (co-resident) or any faculty member of the Department of Internal Medicine aside from an identified PCP. Examples of acceptable documentation include an APP working in an Urgent Care Clinic, an ED provider, or the resident's PCP. Failure to provide this documentation will require payback of the shift covered by the backup resident, arranged by the Chief Resident.

Residents will not be paid for unused sick leave at the end of the year.

✓ **Personal Days**

Residents are granted four personal days to use each academic year. If all four days are not used by the end of the academic year, the resident forfeits any and all of their remaining personal day balance. They are granted and provided for residents to maintain the resident's wellbeing. At least a two-week notice is expected. Days should not be taken during required rotations such as continuity clinic, ICU, cardiology, night medicine and general medicine wards. A form requesting a personal day must be signed by the attending physician and by the Program Coordinator and then submitted to the Department of Medicine. Personal days should only be used and will be granted in one day intervals. Personal days can be revoked at any time during residency by the program director for resident non-compliance with program policies and standards.

✓ **Educational (CME) Leave**

Each resident is provided funds from the university for reimbursement of expenses related to an external conference during each of the three years. The goal of the conference is to update the resident in General Internal Medicine. The following must be met:

a. The conference must be approved by the Program Director.

b. The program agenda must be submitted with the request.

c. At least six hours per day must be devoted to the conference.

d. The content must be devoted primarily to internal medicine or IM procedures.

e. The conference must be in the United States or be the national meeting of a US medical society. Travel to a conference outside the U.S. must have approval from the Chancellor at the UTHSC campus in Memphis.

f. The resident will have to arrange their coverage for the trip if on a core rotation.

Educational leave should be requested 3 months in advance of the trip. The same signatures are required as for vacation leave and must be obtained by the first day of the month prior to the month of the conference. The conference must be a full-day program and not one divided into two to four lectures over a day with the remainder devoted to recreational activities. One-day additional travel time, either to or from the meeting, will be allowed. A total of five weekdays off will be granted for conferences, including travel time. Travel plans, which include completion of a University of Tennessee Authorization for Official Travel Form (T-18), should be coordinated with the Program Coordinator at least one month in advance to secure optimal travel rates. All travel is subject to the University of Tennessee and Erlanger hospital policy and procedures and original receipts are required within 30 days of the travel or expense.

✓ **Leave of Absence, Family Medical Leave, Bereavement Leave**

Please refer to the Institutional GME Leave Policy.

✓ **Special Occasions**

If a special occasion arises after any schedule has been finalized (i.e. wedding of a co-resident or family member, etc.), it is the resident's responsibility to find coverage and facilitate any switch for all core rotations. The coverage arrangement needs to be approved by the Rotation Director and the Chief Resident to prevent major disruptions in patient care.

✓ **Holidays**

Due to the 24-hour nature of patient care, residents are not entitled to holiday leave unless the hospital or program service/clinic closes for that holiday. Time off for a holiday is based on a Resident's or Fellow's rotation assignment. The department may approve time off on a holiday for a resident who is rotating on a clinic or service that closes due to the holiday.

✓ **Away Rotations**

There is a severely limited availability of away rotations (external to the UT College of Medicine Chattanooga and Erlanger). Away rotations will only be approved for rotation/educational opportunities that are not available at Erlanger and are not available for any first-year resident. Away rotations must be discussed with the program director at least 6 months prior to a desired away rotation. Once approved by the Department, away rotations must also be approved by the Associate Dean/DIO, the Dean, and the Erlanger CEO before arrangements can be finalized with the external institution.

Institutional GME Leave Policy (Effective: 7/1/2023)

GME LEAVE POLICY

PURPOSE

The purpose of this GME Leave Policy is to set forth the University of Tennessee College of Medicine – Chattanooga (the "Sponsoring Institution") policies and procedures governing leave for Residents and fellows (individually, a "Resident" or collectively "Residents") participating in graduate medical education ("GME") programs sponsored by UT College of Medicine (each a "Program"). This policy extends to Residents and fellows participating ACGME-accredited and non-standard Programs, as well as extra chief year Residents (individually, a "Resident" or collectively "Residents").

REFERENCE

Consistent with ACGME Institutional Requirements Section IV.H., the Sponsoring Institution must have a vacation and other leaves of absence policy, which among other requirements, provides Residents participating in ACGME-accredited programs with a minimum of six (6) weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws, at least once during a Resident's Program, starting with the day the Resident is required to report. A Sponsoring Institution's vacation and other leaves of absence policy must also ensure that each of its ACGME-accredited Programs provides its Residents with accurate information regarding the impact of an extended leave of absence upon the criteria for satisfactory completion of the Program and upon a Resident's eligibility to participate in examinations by the relevant certifying board(s) (each a "Board"). The policy must include additional components set forth in Section IV.H. of the ACGME Institutional Requirements.

POLICY

I. General Leave Information

Residents shall be afforded annual leave, sick leave, medical, parental and caregiver leave and other leave benefits as set forth in this policy, subject to the conditions or qualifications for leave.

All Programs are required to comply with this policy and shall have policies, consistent with this policy, and ACGME requirements, as applicable, that allow a Resident unable to perform patient care and/or training responsibilities to take an appropriate leave of absence.

All leave must be approved in writing in advance of being taken, per your Program protocol. All Programs are required to use New Innovations to track annual, sick, and educational leave time taken by Residents. Residents are required to submit a GME timesheet to their Program each month listing any annual, sick, educational, or Family Medical leave taken. Leave is available to be taken starting the day the Resident is required to report, the first day of payroll for the Resident (frequently July 1 of the academic year). Leave does not roll over from year to year and Residents may not utilize leave from future academic years in the current academic year. This policy will be available for review by Residents at all times.

II. Annual Leave

Paid annual leave of three (3) weeks, consisting of twenty-one (21) days with a maximum of fifteen (15) "working days" (Monday-Friday) plus six (6) "weekend days" (Saturday-Sunday), may be given per twelve-month period. Annual leave is granted at the discretion of the Program Director and must be approved, in writing, by the Program Director (or his/her designee) in advance. Additional information regarding annual leave documentation may be found in individual Program handbooks. Annual leave must be used for any time away from the Program not specifically covered by other leave benefits below. Residents may use annual leave for interview days. Annual leave does not carry over from year to year and Residents are not paid for unused annual leave. Residents terminating before the end of their training year will be paid only through their final active working day and will not be paid for unused annual leave.

III. Annual Sick Leave

Residents are allotted three (3) weeks of paid sick leave per twelve-month period for absences due to personal or family (spouse, child, or parent) illness or injury. Annual paid sick leave consists of twenty-one (21) days with a maximum of fifteen (15) "working days" (Monday-Friday) plus six (6) "weekend days" (Saturday-Sunday). A physician's statement of illness or injury may be required for absences of more than three (3) consecutive days or an excessive number of days throughout the year. Sick leave is non-cumulative from year to year. Residents are not paid for unused sick leave. Under certain circumstances, additional sick leave without pay may be approved. The Resident may be required to make up any time missed in accordance with Program and Board eligibility requirements.

IV. Regular Annual Family or Medical Leave

Residents who have been employed for at least twelve months and have worked at least 1,250 hours during the previous twelve-month period are eligible for qualified family and medical leave ("FML") under provisions of the federal Family Medical Leave Act ("FMLA"). FMLA provides eligible employees up to twelve (12) weeks of protected unpaid leave for the birth or adoption of a child or a serious health condition affecting the employee or his or her spouse, child, or parent. Except as set forth in Section V, below, Residents may use all available sick and annual leave days to be paid during FML leave.

UTHSC Human Resources ("HR") office has administrative oversight for the FML program. The Program Coordinator or Program Director should notify HR when a Resident may qualify for FML leave. HR will coordinate with GME and the Program Coordinator or Program Director to approve or disapprove a Resident's request for FML leave. Resident rights and responsibilities under FMLA can be found on the GME website: http://uthsc.edu/GME/pdf/fmlarights.pdf. Health and disability insurance benefits for Residents and their eligible dependents during any approved FML shall continue on the same terms and conditions as if the Resident was not on leave. After all available paid sick, annual and other paid leave under Section V has been taken, unpaid leave may be approved under FML and Tennessee law provisions, addressed below.

A. **Tennessee State Law – 4-21-408**. Under Tennessee law, a regular full-time employee who has been employed by the university for at least 12 consecutive months is eligible for up to a maximum of four (4) months leave (paid or unpaid) for adoption, pregnancy, childbirth, and nursing an infant. After all available paid sick and annual leave has been taken, unpaid leave may be approved under FML and Tennessee law provisions. The state benefit and FML benefit run concurrently with paid leave or any leave without pay.

V. ACGME-Mandated One-Time Additional Six Weeks Paid Medical, Parental (Maternity/Paternity), or Caregiver Leave

Each Resident will be provided an ACGME-mandated, one-time additional six (6) weeks (42 calendar days) of paid, approved medical, parental, or caregiver leaves of absence for qualifying reasons that are consistent with applicable laws, at least once and at any time during the Resident's Program, starting on the day the Resident is required to report, the first day of payroll for the Resident (frequently July 1 of the academic year). A Resident, on the Resident's first approved six (6) weeks of medical, parental, or caregiver leave of absence shall be provided the equivalent of one hundred percent (100%) of his or her salary for this leave period.

Health and disability insurance benefits for Residents and their eligible dependents during any approved medical, parental, or caregiver leave(s) of absence shall continue on the same terms and conditions as if the Resident was not on leave.

A. **ACGME One-Time Additional Parental Leave:** Paid parental leave is available to a Resident for the birth or adoption of a child. Each Resident, in an ACGME or non-standard Program, is eligible for six (6) weeks (42 calendar days) of paid parental leave one time during the Program.

A Resident's six (6) weeks of paid parental leave is available in addition to regular annual and sick leave and should be used prior to any remaining annual and sick leave. Paid medical or caregiver leave, below, is part of the same six- week benefit and not in addition to regular paid six-weeks of annual (vacation) leave and six weeks that can be used each year for regular parental leave.

The paid one-time ACGME-mandated parental leave benefit will renew for a second period of eligibility if a Resident continues at the Sponsoring Institution into another Program; but parental leave does not accumulate (for example, for a total of 12 weeks of paid parental leave) if unused by a Resident during a Program. In the event a Resident uses the total of the six (6) week paid parental leave benefit and has or adopts another child while training in the same Program, only the remaining annual and sick leave are available to the Resident as paid time off. All FMLA and other protected unpaid time may still be available to the Resident for leave.

The paid one-time ACGME-mandated parental leave may be used in increments of two-week blocks. Requests for utilization of leave that are less than a two-week block period must be approved in advanced by the Designated Institutional Official. In the event both parents are Residents, the Residents may each use their leave concurrently, overlapping, or consecutively. If desired, this leave may be deferred to a later birth or adoption. Any remaining annual and sick leave may be added after this six-week benefit.

It is the responsibility of the Resident and Program Director to discuss, in advance, what effect taking time off from the training program may have on Board or ACGME requirements dictating a possible extension of training.

B. **ACGME One-Time Additional Resident Medical Leave**: This additional paid Resident Medical Leave is available to a Resident for a serious health condition that makes the Resident unable to perform his or her job. This additional six (6) week (42 calendar days) leave is available one time during the ACGME training Program. Paid medical or caregiver leave is part of the same six-week benefit as the six-week paid parental leave above. This leave will renew for a second period if a Resident continues to a different training Program but the paid time off for medical or caregiver leave does not accumulate if unused. This one-time ACGME-mandated paid Resident Medical leave may be used in increments of two-week blocks. Requests for utilization of leave that are less than a two- week block period must be approved in advanced by the Designated Institutional Official. It is the responsibility of the Resident and Program Director to discuss, in advance, what effect taking time off from the training program may have on Board or ACGME requirements dictating a possible extension of training.

C. **ACGME One-Time Additional Resident Caregiver Leave**: This additional paid Resident Caregiver leave is available for any Resident that needs to take time off for the care of a parent, spouse, or child. This additional six (6) week (42 calendar days) leave is available one time during the ACGME training Program. Paid medical or caregiver leave is part of the same six-week benefit as the six-week paid parental leave above. This leave will renew for a second period if a Resident continues to a different training Program but the paid time off for medical or caregiver leave does not accumulate if unused. Caregiver leave may be used in increments of two- week blocks. Requests for utilization of leave that are less than a two-week block period must be approved in advanced by the Designated Institutional Official. It is the responsibility of the Resident and Program Director to discuss, in advance, what effect taking time off from the training program may have on Board or ACGME requirements dictating a possible extension of training.

VI. Educational Leave

Educational leave is granted at the discretion of the Program Director but may not exceed ten (10) calendar days per twelve-month period. Residents should be advised that some Medical Boards count educational leave as time away from training and may require an extension of their training dates. Interviews are not considered educational leave.

VII. Bereavement Leave

Residents may take up to three (3) days of paid leave due to the death of an immediate family member. Immediate family includes the Resident's spouse, child or stepchild, parent or stepparent, grandparent, grandchild, parent-in-law, foster parent, brother, sister, brother-in-law, sister-in-law, daughter-in-law, or son-in-law of the trainee. With approval of the Program Director, additional time for bereavement may be taken using annual leave or leave without pay.

VIII. Military Leave

Military leaves of absence will be administered in accordance with the University of Tennessee *Personnel Policy*-(https://universitytennessee.policytech.com/dotNet/documents/?docid=129&public=true).
Residents must notify their Program Director when military leave will be required and must provide their Program Director with appropriate documentation of their military service. Depending on the length of leave and Board requirements, training time may be extended.

IX. Jury Duty

A Resident that is summoned for jury duty in federal or state courts in the state of Tennessee must provide a copy of the summons to their Program Coordinator who will provide it to the GME Office. Upon doing so UT College of Medicine will excuse the Resident from work each day the Resident is providing service to the court. The Resident must request a statement from the court clerk each day they are serving on a jury and provide to their Coordinator when they return to work. This court time will not count towards the Resident's annual or sick leave time. This time away from the Program may extend the training time of the Program depending upon Board requirements. This leave does not apply when a Resident is party to litigation which does not involve the UT College of Medicine, i.e., a malpractice lawsuit from their previous institution, and must take annual leave or leave without pay.

X. Time Off to Vote

The UT College of Medicine encourages all employees to vote in local, state, and national elections and provides Residents who are registered voters, reasonable time off to vote in an election held in their local municipality. Residents may receive time off without loss of pay, not to exceed three (3) hours between the opening and closing of polls if the request is made to their Program Director before noon the day prior to the election. Each Program may specify the hours during which the Resident may be absent.

Residents are strongly encouraged to vote during non-working hours. If the polls open three (3) hours or more before the Resident's work schedule begins or if the polls close three (3) or more hours after the Resident's work schedule ends, the Resident may not receive time off to vote.

XI. Holiday Leave

Due to the 24-hour nature of patient care, Residents are not entitled to holiday leave. A Program Director may approve time off on a holiday for a Resident who is rotating on a clinic or service that closes due to the holiday or may reassign the Resident to another location.

XII. Religious/Cultural Holidays and Activities

The UT College of Medicine employs a remarkably diverse workforce and as such will try to reasonably accommodate requests for specific days off when requested. Residents are not entitled to holiday leave. However, when a Resident desires to have a specific day off due to a religious holiday, the Program should try to accommodate as possible. Time off for religious/cultural holidays and activities is not considered paid holiday leave, but may be scheduled to align with a Resident's required 1 in 7 days off or taken as part of annual leave, etc. The same reasonable accommodation should be granted, when possible, for other religious activities, such as daily prayer, fasting, etc. which may be accommodated through leave, schedule adjustments, call coverage changes, etc. A request is not guaranteed for approval but will be accommodated when possible. The Office of Equity and Diversity (www.uthsc.edu/oed) is the official office that facilitates accommodation requests for the campus. Residents with questions regarding the process should call 901.448.2112 or email (hsc-oed@uthsc.edu).

XIII. Administrative Closings/Inclement Weather

Residents are essential personnel and provide essential services. The University, including UT College of Medicine, may close its administrative offices during inclement weather for those individuals classified as non-essential regular staff employees. Residents, however, provide direct patient care in our hospitals and clinics and must report to training and work as scheduled. If a clinical site closes a clinic or service and does not require the Resident's attendance, the clinic manager or attending will notify the Resident and/or Program Director as soon as possible. The Resident must notify the Program Director if the Resident is instructed that his/her clinical service is closed due to weather. The Program Director may elect to reassign a Resident to another clinical assignment for patient care or allow the Resident to stay home without having to use annual leave. If a clinical site/service remains open to provide essential patient care and the Resident is unable to report to training/work due to travel/weather conditions, then the absence shall be charged as annual leave. Residents must notify their attending/site director and Program Director as soon as possible that an absence is required. The Program Director, or designee, is the only individual that may have final approval for the Resident to stay home.

XIV. Impact of Leave of Absence

A. **General Impact of Leave:** An extended absence, for any reason, may prevent a Resident from fulfilling the requirements for participation in educational and scholarly activities and achieving the residency/fellowship responsibilities as further described in the UT College of Medicine GME *Agreement of Appointment*. Generally, leaves of absence will be granted for a maximum of six (6) months. Residents are subject to termination upon a) exhaustion of all available annual leave, sick leave and other approved or statutory leave, or b) failure to return to work as scheduled at the end of the authorized or statutory leave.

An absence will be charged against any accrued annual, sick, or other available approved unpaid leave program. If all such paid and unpaid leaves are exhausted, the absence will be unexcused and the Resident subject to dismissal for job abandonment. The GME Assistant Dean, in his/her discretion, may authorize additional leave but only in extraordinary circumstances. Programs and Residents are advised that:

- Residency positions will be protected during the period of approved FML or as required by law.
- Residency positions in a prescribed Aid for Impaired Residents program may be protected as described in UT College of Medicine GME *Aid for Impaired Residents Policy*.
- An unpaid leave of absence may affect a Resident's visa status.
- A leave of absence may require extension of training to meet Program or Board eligibility criteria.

B. **Compliance with Board Requirements for Absence from Training:** It is the responsibility of the Program Director to verify the effect any absence from training will have on a Resident's ability to finish on time and meet ACGME Review Committee and Board eligibility requirements. All approved training extensions necessary to meet Board eligibility are paid with full benefits.

Board certification eligibility information is provided to Residents by each Program and can also be accessed through the American Board of Medical Specialties: http://www.abms.org.

C. **Extension of Training**: If an extension of training is required, Residents are allocated additional annual and sick leave according to the following:
- Less than three (3) months – no additional leave
- Three (3) to six (6) months – 25% of the leave allocated within a twelve-month period
- Six (6) to nine (9) months – 50% of the leave allocated within a twelve-month period
- Nine (9) to less than twelve (12) months – 75% of the leave allocated within a twelve-month period
- Additional year of training twelve (12) months – all paid leave equivalent to an entire academic year is allocated

D. **Consequences of Unapproved Leave**: Failure to comply with leave policies, including obtaining written prior approval, may result in leave without pay and may be reflected in the Resident's final summative evaluation as a professionalism issue.

Approved by the GMEC May 2022. Addition administrative edits made effective July 1, 2023.

Official ABIM Leave Policy: https://www.abim.org/Media/splbmcpe/policies-and-procedures.pdf

SPECIAL TRAINING POLICIES

Disclosure of Performance Information

Trainees planning to change programs must direct requests to their current program and to ABIM to send written evaluations of past performance to the new program. These requests must be made in writing and in a timely manner to ensure that the new program director has the performance evaluations for review before offering a position. In addition, a new program director may request performance evaluations from previous programs and from ABIM concerning trainees who have joined the new program. ABIM will respond to written requests from trainees and program directors by providing any performance evaluations it has in its possession and the total credits accumulated toward ABIM's training requirements for Board Certification. This information will include any comments provided with the evaluation.

Responsibility for Evaluations

The responsibility for the evaluation of a trainee's competence in the six ACGME/ABMS Competencies and overall clinical competence rests with the program director, not with ABIM. ABIM is not in a position to re-examine the facts and circumstances of an individual's performance. As required by the ACGME in its Essentials of Accredited Residencies in Graduate Medical Education, the educational institution must provide appropriate due process for its decisions regarding a trainee's performance.

Leave of Absence and Vacation

This policy applies to internal medicine residency and subspecialty fellowships in all ABIM disciplines.

Up to 5 weeks (35 days) per academic year are cumulatively permitted over the course of the training program for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities. For example, a resident could take 105 days of leave during a three-year internal medicine residency without needing to extend training. Training must be extended to make up any absences exceeding 5 weeks (35 days) per year of training unless the Deficits in Required Training Time policy is used. 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 does not establish how much time per year should be used for vacation and recognizes that leave policies vary from institution to institution. Program Directors may apply their local requirements within these guidelines to ensure trainees have completed the requisite period of training with adequate vacation over the total training duration.

ABIM considers activities such as attendance at training-related seminars, courses, interviews for subsequent training positions or jobs, etc., as bona fide educational experiences or duties essential for the continuity of education in internal medicine and its subspecialties. These activities need not be counted as part of the allocation for leave time in the academic year for purposes of tracking training time for ABIM. Similarly, ABIM does not require that this time be counted among the educational experiences of the training program; rather, the program director has the discretion to apply this policy to ensure the balance of time needed to assure competency in the discipline is achieved at the end of training.

This policy, along with ABIM's Deficits in Required Training Time policy, provides for time away from training in excess of the minimum requirements of the ABMS Leave Policy, as revised in July 2021. Under the ABMS policy, "Member Boards with requirements that allow for more than six weeks of time away from training for any purpose including parental, caregiver and medical leave are in compliance with the above policy." (ABMS Leave Policy, Appendix, ¶ 3.) ABIM's policies allow for more than six weeks of time away from training for any purpose.

Should training need to be extended, candidates may still be eligible for certification the year of graduation provided that they complete the training requirements by the August 31st (IM) or October 31st (SS) deadline.

DURATION OF TRAINING REQUIREMENT	LEAVE TIME (CUMULATIVELY AVAILABLE OVER DURATION OF TRAINING)	ADDITION WITH DEFICITS IN REQUIRED TRAINING TIME IF COMPETENT AT END OF TRAINING	TOTAL TIME AWAY FROM TRAINING PERMITTED
1 Year Program (E.g. Geriatrics)	35 days	35 days	70 days
2 Year Program (E.g. Nephrology)	70 days	35 days	105 days
3 Year Program (E.g. IM Residency, Cardiology fellowship)	105 days	35 days	140 days

Deficits in Required Training Time

This policy applies to internal medicine residency and subspecialty fellowships in all ABIM disciplines.

ABIM recognizes that delays or interruptions may arise during training such that the required training cannot be completed within the standard total training time for the training type. In such circumstances, if the trainee's program director and clinical competency committee attest to ABIM that the trainee has achieved required competence with a deficit of less than 5 weeks (35 days), extended training may not be required. Only program directors may request that ABIM apply the Deficits in Required Training Time policy on a trainee's behalf, and such a request may only be made during the trainee's final year of training. Program directors may request a deficit in training time when submitting evaluations for the final

year of standard training via FasTrack, subject to ABIM review.

The Deficits in Required Training Time policy is not intended to be used to shorten training before the end of the academic year.

Examples:

- A rheumatology trainee beginning training on July 1, 2022 anticipates a completion date by June 30, 2024. A six week medical leave in the F-1 year causes the total cumulative leave over the 24-month training period to exceed the 70 days of permitted leave by ten days and extending the completion date until July 10, 2024.
- An internal medicine trainee beginning training on July 27, 2021 (27 days off-cycle due to a visa delay) anticipates a completion date by July 26, 2024.

In each example, the trainee may complete training on June 30 if:

- The program attests to the trainee's achieving the required competence on June 30, 2024
- The program documents the reason for the deficit in training on the trainee's final year ABIM FasTrack® evaluation, and
- ABIM approves the program director's request to apply the Deficits in Required Training Time policy.

The Deficits in Required Training Time policy is not intended to be used to shorten training before the end of the academic year.

Example:

- An internal medicine trainee who initiated training on July 1, 2021 and anticipates a completion by June 30, 2024 may not use the Deficits in Required Training Time policy in an effort to truncate their training (e.g., to enter a fellowship prior to July 1, 2024).

Definition of Full-Time Training

Full-time training is defined as daily assignments for periods of no less than one month to supervised patient care, educational, or research activities designed to fulfill the goals of the training program. Full-time training must include formative and summative evaluation of clinical performance, with direct observation by faculty and senior trainees.

Transition to the ACGME/AOA Single GME Accreditation System

Beginning in July 2015, for residents and fellows who begin training in an AOA-accredited program which receives ACGME accreditation before graduation, all satisfactorily completed years of training will be accepted towards ABIM's initial certification eligibility requirements. To be granted admission to an ABIM Certification Examination, candidates must meet all applicable training, licensure, professional standing and procedural requirements.

Through its tracking process, FasTrack®, ABIM requires verification of trainees' initial certification eligibility criteria from an ABIM certified program director (other ABMS Member Board and Canadian certification is acceptable, if applicable). In support of the Single GME Accreditation System, ABIM recognized the need for a change in eligibility policies to allow program directors of newly accredited programs to become certified by ABIM and for a transition period to allow them to do so. That period has been extended through 2023. If the program director of a program achieving accreditation through the Single GME Accreditation System is not currently certified by ABIM in the discipline for which they are program director, there is a Special Consideration Pathway which will allow the program director to become certified by ABIM.

Through the end of 2023, ABIM will accept attestations for ABIM initial certification eligibility criteria from those who are program directors through the Single GME Accreditation System, but who have not yet become ABIM certified in the discipline of their program. Beginning in 2024, all attestations of ABIM initial certification eligibility criteria will need to come from program directors who are ABIM certified in the discipline of their program. For additional information, please see the "Clinical Competence Requirements" section under each certification area.

Interrupted Full-Time Training

ABIM approval must be obtained before initiating an interrupted training plan. Interrupted full-time training is acceptable, provided that no period of full-time training is less than one month. In any 12-month period, at least six months should be spent in training. During training periods, patient care responsibilities should be maintained in a continuity clinic consistent with ACGME program requirements for the discipline. Part-time training, whether or not continuous, is not acceptable.

Qualifying Board

A Qualifying Board is an ABMS Member Board whose diplomates may apply for a subspecialty certificate through another Member Board and, if successful, participate in their continuing certification program. Once certified in the subspecialty, the diplomate of the Qualifying Board becomes a diplomate of the sponsoring Board for the subspecialty and must meet all of the sponsoring Board's requirements for initial certification and Maintenance of Certification (MOC) in the discipline. The physician's original board no longer manages their certification and MOC for the subspecialty.

Competency-Based Medical Education Pilots

The American Board of Internal Medicine (ABIM) does not approve program-level CBME pilots; however, ABIM is pleased to coordinate with the Accreditation Council for Graduate Medical Education (ACGME) Advancing Innovation in Residency Education (AIRE) program by prospectively reviewing proposals to determine how they may affect eligibility for initial certification in ABIM disciplines.

Requests for an ABIM letter of support for an ACGME AIRE proposal can be sent to AcademicAffairs@abim.org.

REIMBURSEMENT FOR PROFESSIONAL EDUCATIONAL DEVELOPMENT AND TRAVEL

The Internal Medicine Residency Program has allocated the following annual funding per resident for professional development:

PGY-1: $650
PGY-2: $900
PGY-3: $1,200

All reimbursement for educational materials and travel must be within University of Tennessee fiscal policy guidelines and our UT GME policies.

Regarding reimbursement of books or other non-travel related educational expenses; the resident must have already paid for the items prior to requesting reimbursement. Original receipts must be submitted to the Department of Medicine staff within 30 days of the expense. Residents should allow three weeks for processing from the time the request is received in the Graduate Medical Education (GME) Office. Any unused educational reimbursement at the end of June cannot be carried over to the next year. Payment and reimbursement for educational conferences and materials is provided by the UT Business Office and not by the Department of Internal Medicine.

Approved reimbursable expenses if funds are available:

- Travel expenses to approved CME conferences planned by ACCME accredited providers.
    - Conferences should be in a specialty related to the Resident's training and career plans and must be in the continental US or the national meeting of a specialty society or organization.
    - Prior travel authorization and review of the conference brochure or website details must be documented by the department. It is recommended that travel be arranged through the University of Tennessee recognized travel agency.
- Electronic or web-based educational materials.
- Video course registration.
- Hard copy medical-related books.
- Board Reviews (hard copy or digital).
- USMLE Step 3/COMLEX Level 3 Prep Course or materials.
- Membership fee for specialty organizations.
- USMLE Step 3/COMLEX Level 3 registration fee.
- Smart phone ($250 allowance).
- iPad or similar tablet ($250 allowance).
- Laptop computer ($250 allowance).
- Small medical equipment such as a stethoscope, surgical loupes, or neural reflex hammer.
- Question bank or academic resource subscriptions for one year.
- Encrypted portable USB drive.
- Certification board exam fees.

Purchase and reimbursement for these educational and professional development expenses must be approved by the Chair and/or Program Director, accompanied by original receipts, and an appropriate expense form must be provided by the Resident and Residency Program Coordinator. Once receipts and expenses have been approved and submitted within the university financial system (IRIS), reimbursement will be processed, and payment will be issued via direct deposit into your primary bank account on file.

Receipts and expenses should be submitted within 30 days of purchase of items or travel. The deadline for submitting all Resident reimbursement receipts, explanations, and travel expense reports to the Business Office each academic year is April 1, except for travel that has been pre-approved but has not yet occurred by April 1.

For Travel Reimbursement from the university, a UT travel request (T18) must be submitted 1 month prior to travel. To be reimbursed for flights, must have original receipt with breakdown of taxes/fees and the receipt must denote coach fare. To be reimbursed for hotel, must have original receipt from hotel with breakdown on nightly rate, taxes/fees. Rental cars are NOT reimbursable under normal circumstances. Receipts from travel sites such as Expedia, Travelocity, Orbitz, etc., generally will not be honored. No package deals which include airfare, hotel, and car rental are permitted through these type of travel sites – under any circumstances. The University recommends that you arrange travel through the UT recognized travel agency, World Travel, to ensure that all University policies are followed, and receipts will meet requirements.

ESAFE

Patient safety and quality improvement are of paramount importance in Internal Medicine. If there is a patient care situation that is a near miss, error, or system issue that negatively impacts patient care please submit a report via the Erlanger e-Safe Occurrence and Complaint Reporting system. The link is available on the Erlanger Intranet Home page (from an Erlanger computer or through the Physician Portal) on the Application Link on the right-hand menu area. Use your Erlanger computer network login and password to access.

MEDICAL RECORD COMPLETION POLICY

Inpatient Rotations

- All H&Ps need to be completed the day of admission
- Discharge Summaries should be completed the same day and should not exceed 24 hours.
- Discharge summaries need to be completed on all patients admitted to the hospital, including those admitted for 23-hour observation.
- All records need to be signed in a timely manner.
- Any records exceeding 7 days are delinquent.
- Records exceeding 14 days will require action by the department.

Continuity Clinic

- Notes should be completed prior to leaving clinic.
- Inboxes need to be checked daily even while on other rotations outside of the clinic week assignment.

Discharge Summaries

All patients discharged to nursing homes or other medical facilities must have a completed discharge summary to accompany the patient. All other discharge summaries (patients discharged to home) must be dictated within 24 hours of discharge, and preferably on the day of discharge. All patients require a discharge summary, including those admitted for 23-hour observation.

BACKUP COVERAGE SYSTEM (AKA "JEOPARDY SYSTEM")

The backup coverage system for vital clinical service roles termed historically as the jeopardy system exists to provide back-up for residents who find themselves unexpectedly unable to work their assigned rotation due to illness or personal emergency. Jeopardy system structure and rules:

1. Be professional, responsible, and conscientious
    - This system is to be used ONLY when absolutely needed for sickness or personal emergency, so please use it responsibly.
    - Please do not abuse this jeopardy system and be mindful of your co-residents' time and life.
    - Any abuse to the system will not be tolerated and will have consequences.

2. The person assigned to jeopardy must be available 24 hours a day for the duration of their jeopardy coverage.
    a. That means:
        - Able to make it to the hospital within 1 hour, preferably stay in town.
        - Make sure your cell phone and pager are on and working 24/7.
        - Be professional and responsible (sober and able to work).
        - Failure to answer jeopardy call is a breach to professionalism and has consequences.

3. Coverage
    - Interns are not scheduled for backup coverage.
    - There will be senior residents assigned to backup. They will be listed as First Call, Second Call, etc.
    - The chief resident and/or program leadership will utilize the system as needed and provide any needed clarification(s) to those pulled residents.

4. Jeopardy call process:
    1. Call the Chief Resident to inform him/her of inability to work and reason.
        - You must call.
            - Text messages and emails are not acceptable.
        - You must call before your scheduled shift.
            - Please do not wait until your shift has already started.
        - Informing the Chief of absence from work after the work shift is done is not acceptable and is considered a breach of professionalism.
    2. Chief will call the resident on <u>First Call.</u>
        - You will be called on your cell phone first.
            - Please make sure it is working and charged (24/7).

- If cell phone is not answered, your emergency contact will be called.
- You have 15 minutes to answer the jeopardy call. Failure to answer a jeopardy call within this time is a breach to professionalism.

3. If 2nd coverage is needed, the chief will call the resident listed on Second Call.
   - Same procedure will apply.

5. Consequences
   - Any abuse to the system will not be tolerated and will result in pay back for resident who was pulled for coverage.
   - Failure to answer jeopardy call is a breach to professionalism and will result in pay back of the shift missed or to resident who was pulled instead.

6. Jeopardy Exchanges
   - You can only switch on a consult time.
     - Switching from jeopardy on consult to jeopardy on clinic will not be accepted.
   - You should switch a First Call with a First Call and Second Call with a Second Call.

DIDACTIC CONFERENCES

- The program produces a monthly schedule which is distributed to all residents and faculty.
- Required conferences include case ("morning") report, educational content conferences, journal club, patient safety conferences (M&M), weekly continuity clinic YOBM conferences, and grand rounds.
- Please be respectful of the presenter and be on time.
- Residents are expected to attend all conferences when on rotations during the day in the hospital unless an unstable patient requires attention.
- Residents on night float, scheduled off-days, vacation, and off-site rotations are not expected to be present, but all others should be in attendance.
- Residents are responsible for the accuracy of all conference sign-in logs. A minimum attendance rate of 70% is required to remain compliant and in good standing with the program.
- Signing in for days not attended or for other residents is unethical and unprofessional and will result in disciplinary action.

MOONLIGHTING

- Interns are not allowed to moonlight.
- PGY2 and PGY3 residents desiring to moonlight must notify and have written permission from the program director prior to moonlighting
- Those upper-level residents below the 30th percentile on the ITE will not be permitted to moonlight.

- The departmental request form included at the end of this manual must be submitted prior to the scheduled activity.
- All residents desiring to moonlight must obtain a Tennessee Medical license and malpractice insurance coverage for any professional work outside of residency activities. The Tennessee State Claims Commission, which provides immunity from professional liability for residents when functioning as a resident in our GME Programs and when acting within their training responsibilities, does not provide malpractice coverage for moonlighting activities.
- Moonlighting schedules must be logged on New Innovations within 24 hours of doing the activity.
- No moonlighting is allowed during any inpatient rotation.
- Moonlighting hours must be logged into New Innovations and total duty hours (residency shifts + moonlighting) may NOT exceed 80 hours per week.
- Moonlighting schedules should not interfere with your regular duties. Residents should not leave their rotation site early or before their duties are completed to begin a moonlighting shift.
- Moonlighting must not interfere with meeting the requirement of having at least 8 hours between work assignments.
- Failure to comply with the above or marginal-to-unsatisfactory evaluations will result in loss of moonlighting privileges. See the GME Moonlighting Policy via the below link.
- Failure to comply with the above or marginal-to-unsatisfactory evaluations will result in loss of moonlighting privileges.

MEDICAL STUDENTS

The Clerkship Director will ultimately dictate student requirements. If a concern arises regarding student performance or professionalism, this should be brought to the attention of the Clerkship Director immediately. Separate and complete materials for medical students will be sent by Dr. Koo and the assigned resident liaisons.

Resident liaisons:

PGY2 – Mary Mangieri
PGY3 – Christopher Adams

ACLS CODE COMPETENCY

Internal Medicine PGY 2 and PGY 3 residents are responsible for leading codes throughout the hospital (except for the closed ICUs). In preparation for this, rising PGY2 will be scheduled for an "ACLS check off", as well as mandatory meet and greets with core members of the code team ("Red Shirts"). The "ACLS Check off" consists of a code simulation on a high-fidelity mannequin lead by the rising PGY2. The resident will perform the simulation on their own, with faculty members acting as ancillary staff. Residents are graded with a competency evaluation made up of core ACLS skills based upon the American Heart Association certification parameters as determined by the faculty members involved in the simulation. A passing score is considered 12 out of 15 points on the skills evaluation. Any resident who has not passed can have one on one faculty coaching on ACLS skills before performing the check off simulation activity again.

PROGRAM EVALUATION COMMITTEE (PEC)

The PEC is responsible for the planning, developing, implementing, and evaluating educational activities of the program. The committee reviews and makes recommendations for revision of competency-based curriculum goals and objectives and addresses areas of non-compliance with ACGME standards. The group will review the program annually using evaluations of faculty, residents, and others. The program, through the PEC, will document a formal systematic evaluation of the curriculum annually. The committee will render a written annual program evaluation.

Members include:

- The Program Director (who serves as chair of the committee).
- All Associate Program Directors.
- The Department Chair.
- The Chief Resident.
- 6 peer selected residents, 2 from each class.
- 1 faculty representative from each division as appointed by each respective Division Chief. The Division Chief serves if no faculty member can be appointed.

Members of the PEC are defined as core faculty and entered into the ACGME accreditation system as such.

The program must monitor and track each of the following areas:

Resident performance

a. including outcome assessment of the educational effectiveness of inpatient and ambulatory teaching (*i.e.,* In-Training Exam results)

Faculty development

Graduate performance

- At least 80% of those completing their training in the program for the most recently defined three-year period must have taken the certifying examination
- The program's graduates must achieve a pass rate on the certifying examination of the ABIM of at least 80% for first-time takers of the examination in the most recently defined three-year period

Program Quality

- Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually.
- The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program.

Monitor progress on the previous year's action plan

- The ability to retain qualified residents by graduating at least 80% of its entering categorical residents averaged over the most recent three-year period.

The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in the section, as well as delineate how they will be measured and monitored.

The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

- The department should share appropriate inpatient and outpatient faculty performance data with the program director.
- The program must organize representative program personnel, at a minimum to include the program director, representative faculty, and one resident, to review program goals and objectives, and the effectiveness with which they are achieved.

PROGRAM EVALUATION

The residency program values the input of residents and faculty alike to continually improve the quality of the residency training program. Each year the residency program undergoes a thorough evaluation of all aspects of resident education. All residents and faculty will receive an anonymous survey to provide feedback and voice concerns about any element of the residency training program. In a subsequent meeting of faculty and residents, the surveys, and any other information relevant to the residency training program will be reviewed. The product of this meeting will be an overall assessment of the program as well as an action list of important elements of the program that can be enhanced.

The program evaluation will consider the following:

1. Anonymous Resident Program Evaluation of --

    - Didactics conferences/curriculum
    - Rotation goals and objectives and evaluations
    - Curriculum as a whole
    - Quality of supervision

2. Anonymous Faculty Program Evaluation of --

    - Strengths of and areas of improvement concerning:
        i. Residents
        ii. Rotations
        iii. Faculty
        iv. Continuity Clinic
        v. Education

3. Duty Hours monitoring results.

4. ABIM board pass rates.

5. ACP In-Training Examination performance.
6. Most recent ACGME Accreditation Letter.
7. Most recent ACGME Resident/Faculty Survey results.

PROFESSIONALISM

The University of Tennessee College of Medicine Chattanooga Internal Medicine Residency Program expects all residents to abide by the professionalism and ethical behavior tenets established in two separate documents:

- University of Tennessee College of Medicine Chattanooga Internal Medicine Residency Program Guidelines
- University of Tennessee College of Medicine Chattanooga GME Institutional Policy

UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE CHATTANOOGA INSTITUTIONAL REQUIREMENTS

It is the policy of the University of Tennessee College of Medicine Chattanooga (UTCOM Chattanooga) to treat all individuals within the Erlanger Health System or any other facility in which patient care and/or training is being conducted, with courtesy, respect, and dignity. To that end, the UTCOM Chattanooga requires that all individuals (Faculty, Residents*, Medical Students, and staff) conduct themselves in a professional and cooperative manner. It is also the policy of UTCOM Chattanooga to be sensitive to a practitioner's health or condition that may adversely affect that individual's ability to provide safe, competent care to his or her patients. The concern is for high-quality patient care always, but it is accompanied by compassion for the practitioner whose abilities may be diminished in some way due to age, medical illness, substance abuse, impairment, or disruptive behavior. It is the responsibility of the UTCOM Chattanooga to investigate and respond to unprofessional, impaired, or disruptive behaviors.

Definitions:

Impairment – A change in the health status of an individual that jeopardizes the practitioner's ability to carry out his or her delineated privileges with good quality. Examples may include but not be limited to:

- Stress
- Burnout
- Deterioration through the aging process
- Loss of motor skills

Acute Impairment – May be derived from substance abuse/dependence, physiological, emotional, or psychological difficulty and may be evidenced by a variety of behaviors or other observations not limited to a single event or episode.

Disruptive Behavior – Exhibitions of a pattern of behavior characterized by one or more of the following actions:

- Use of threatening or abusive language directed at nurses, hospital personnel or other physicians.

- Use of degrading or demeaning comments regarding patients, families, nurses, physicians, hospital personnel, or the hospital.

- Use of profanity or other grossly offensive language while in a professional setting.

- Use of threatening or intimidating physical contact.

- Making public derogatory comments about the quality of care being provided by other physicians, nursing personnel, or the hospital, rather than working through the peer review process or other avenues to address these issues.

- Writing inappropriate medical records entries concerning the quality of care provided by the hospital or any individual.

WELLBEING CHARTER

Well-being encompasses physical health as well as mental, emotional, and financial health. It is vital these aspects are incorporated, as best as possible, into personal and work life as imbalance can contribute to increased stress and possibly burnout. There are different commitments which, if addressed by the institution can lead to better understanding of well-being for physicians and how satisfaction can be improved[1]. At the University of Tennessee College of Medicine Chattanooga Internal Medicine Residency Program, it is our mission to facilitate this balance.

Residents will be given twelve personal days over the three years which can be used at their discretion for anything which would contribute to the betterment of their well-being. Four days are allocated annually to each resident and do not roll over to the following year. Throughout the academic year, individualized wellness time is allocated during the normal noon conference hour. It can be used for fellowship with other residents or however the individual sees fit to use the time. Residents are also afforded wellness half days during their ambulatory weeks.

Activities outside of the program are planned, at least quarterly, which have included in the past of going to a minor league baseball game, attending a movie as a group or a game night. Protected retreats will be planned for residents. Our retreat's primary goal is use this time to be engaged with their fellow residents and leadership, while also discussing topics which pertain to their growth as an individual and as a clinician.

Outside of the internal medicine program, there are numerous resources available to the residents through the College of Medicine (https://uthsc.edu/comc/well-being/index.php) that we encourage all residents to be aware of and use regularly.

The program would like all trainees to be familiar with the Collaborative for Healing and Renewal in Medicine (CHARM) Wellness Charter and its four guiding principles[1]:

- Patient care:

    - Effective patient care promotes and requires physician well-being.
- Well-being of all:
    - Physician well-being is related with the well-being of all members of the health care team.
- High-value care:
    - Physician well-being is a quality marker.
- Shared responsibility:
    - Physician well-being requires collaboration between individual physicians and their organizations.

The program takes the well-being of every resident seriously and with utmost importance. Recognition of burnout by trainees and faculty is encouraged and we will intervene to limit the effects of continued burnout to all residents. Time for regeneration and maintenance of preventive health care needs is a cornerstone of our residency program. Residents within one month of starting residency should establish with a primary care physician and will be provided time to attend all necessary appointments.

We will be responsible for administering a formal faculty mentoring program available to every resident. Residents will be matched with a seasoned faculty member that has career expertise relative to the resident's anticipated career path. Faculty mentors will also be someone available to residents who can help them manage aspects relative to well-being.

Your well-being is a group effort. We are all in this together – you are not alone.

Additional Resources Available to All Residents -- https://www.uthsc.edu/comc/well-being/index.php

APPENDIX A: MOONLIGHTING PERMISSION DOCUMENTATION

University of Tennessee College of Medicine Chattanooga Internal Medicine Residency Program
Program Director Approval Form for Academic Year 2024 – 2025

Effective _____, permission is granted for (*Printed Resident Name*) _____

to moonlight through **June 30, 2025** for (company or institution):

Name of Moonlighting Activity:

Address of Moonlighting Activity:

Telephone Number for Moonlighting Activity:

(Initial all)

_____ Moonlighting is <u>not</u> a requirement of internal medicine residency training.

_____ All moonlighting activities must be in compliance with ACGME requirements for duty hours:

External Moonlighting

- All clinical and academic activity (including moonlighting) must be limited to 80 hours per week, averaged over a 4-week period.

Internal Moonlighting

- All clinical and academic activity (including moonlighting) must be limited to 80 hours per week, averaged over a 4-week period.
- You are prohibited from participating in any patient care activities (including moonlighting) after 24-hours of continuous duty.
- All in-house on call activities consisting of 24 hours of continuous duty must be followed by a 14-hour rest period in which there are no clinical, administrative, educational activities or moonlighting.

_____ Residents must track their moonlighting hours monthly in New Innovations and assure compliance with ACGME requirements.

_____ Moonlighting must never interfere with the goals and objectives of the residency program.

- You are not to leave duties early, arrive late, alter your team's rounding schedule, or fail to perform any of your duties because of your moonlighting activities.
- You may not be on call (even home call or on the “pull list”) and simultaneously moonlight.

_____ Violations of these guidelines will result in you being brought before the Clinical Competency Committee and may result in the summary termination of your appointment.

Resident	Signature: X_____
Internal Medicine Program Director	Signature: X_____
Department Chair	Signature: X_____
Designated Institutional Officer (DIO)	Signature: X_____

APPENDIX B: RESEARCH ELECTIVE FORM

University of Tennessee College of Medicine Chattanooga
Internal Medicine Residency Program Research Rotation Form

Resident Name:	**PGY:**
Dates of Elective:	
Description of Experience: *Provide a brief description of activity:* _____ _____ *Goals: What do you hope to achieve during this elective experience (minimum of 2)?* *(1)* _____ (2) _____	
Faculty Preceptor(s): ***Who has agreed to supervise the learning experience &complete your evaluation****?*	
Preceptor Department or Division:	

Fill in your anticipated weekly schedule. Include all **proposed elective activities and location**.

	MON	TUES	WED	THURS	FRI
AM					
(12-1:30)	**← ATTENDANCE TO CONFERENCE REQUIRED UNLESS EXCUSED →**				
PM					

Approved: _____ Date: _____
Research Rotation Faculty Mentor

Approved: _____ Date: _____
Internal Medicine Residency Program Director Signature

APPENDIX C: INPATIENT DIRECT OBSERVATION FORM

Evaluator Name:	**Resident Name:**	**Date:**
Patient Problem/Dx:		

Setting	**Age**	**Sex**	**Complexity**	**Focus**
❑ Cardiology ❑ Critical Care ❑ General Medicine Wards ❑ Other: (specify below)		❑ Female ❑ Male	❑ Low ❑ Moderate ❑ High	❑ Data gathering ❑ Diagnosis ❑ Therapy ❑ Counseling

EVALUATION

Circle or place an "X" on the number that corresponds to your evaluation rating

Criteria/Rating		DID NOT OBSERVED	UNSATISFACTORY			SATISFACTORY			EXCELLENT			SUPERIOR
1	Medical Interview Skills	0	1	2	3	4	5	6	7	8	9	10
2	Physical Examination Skills	0	1	2	3	4	5	6	7	8	9	10
3	Humanistic Qualities & Professionalism	0	1	2	3	4	5	6	7	8	9	10
4	Clinical Judgment	0	1	2	3	4	5	6	7	8	9	10
5	Counseling Skills	0	1	2	3	4	5	6	7	8	9	10
6	Organization/Efficiency	0	1	2	3	4	5	6	7	8	9	10
7	Overall Clinical Competence	0	1	2	3	4	5	6	7	8	9	10
8	How much time did you spend on the evaluation?➔		How many minutes did you observe? How many minutes did you provide feedback?									
9	How satisfied are you with this Mini-CEX?		LOW									HIGH
	Evaluator		1	2	3	4	5	6	7	8	9	10
	Resident		1	2	3	4	5	6	7	8	9	10

Comments *(continue on other side if needed)*

Resident Signature:	Evaluator Signature:

DESCRIPTORS OF COMPETENCIES DEMONSTRATED DURING THE DIRECT OBSERVATION/MINI-CEX

Medical Interviewing Skills: Facilitates patient's telling of story; effectively uses questions/directions to obtain accurate, adequate information needed; responds appropriately to affect, non-verbal cues.

Physical Examination Skills: Follows efficient, logical sequence; balances screening/diagnostic steps for problem; informs patient; sensitive to patient's comfort, modesty.

Humanistic Qualities/Professionalism: Shows respect, compassion, empathy, establishes trust; attends to patient's needs of comfort, modesty, confidentiality, information.

Clinical Judgment: Selectively orders/performs appropriate diagnostic studies, considers risks, benefits

Counseling Skills: Explains rationale for test/treatment, obtains patient's consent, educates/counsels regarding management.

Organization/Efficiency: Prioritizes; is timely; succinct.

Overall Clinical Competence: Demonstrates judgment, synthesis, caring, effectiveness, and efficiency.

Note 1: Reprinted with permission from the American Board of Internal Medicine, www.abim.org.

Note 2: Discussed in: Norcini JJ, Blank LL, Arnold GK, Kimball HR. The mini-CEX (Clinical Evaluation Exercise): a preliminary investigation. Ann Intern Med 1995; 123:795-9.

APPENDIX D: OUTPATIENT MEDICINE DIRECT OBSERVATION FORM

Resident:	Attending:		Date:
Patient Age:	☐ New	☐ Follow-up	☐ Preventive Healthcare

	Unsatisfactory	Needs Improvement	Satisfactory	Superior	N/A
History-Taking:					
1. Obtain a relevant and pertinent history	☐	☐	☐	☐	☐
2. Respond to patient/parent concerns and cues during the encounter	☐	☐	☐	☐	☐
3. Complete a relevant and pertinent physical exam	☐	☐	☐	☐	☐
Patient Management:					
4. Effectively explain the management plan to the patient without medical jargon	☐	☐	☐	☐	☐
5. Include the patient in medical decision-making	☐	☐	☐	☐	☐
6. Management plan reflects cost awareness and risk-benefit analysis	☐	☐	☐	☐	☐
Patient/Family Education:					
7. Effectively counsel patient/parent regarding health promotion and disease prevention	☐	☐	☐	☐	☐
8. Actively assist patient/parent in dealing with system complexities	☐	☐	☐	☐	☐
Professionalism:					
9. Behave in a sympathetic and caring manner toward the patient/parent	☐	☐	☐	☐	☐
10. Demonstrate sensitivity toward the patient's/parent's background	☐	☐	☐	☐	☐

Resident Reflection on Patient Encounter (How do you think the visit went?):

Attending Comments:

Resident Signature

Attending Signature

APPENDIX E: HANDOVER EVALUATION FORM

Faculty Evaluator Name: _____ Evaluation Date: _____

Resident Name: _____ # of patients handed off: _____

Setting/Situational Overview	Circle Answer	
Was the room sufficiently quiet with minimal distractions?	Yes	No
Was a situational overview provided by the resident giving the handoff (e.g. description of the "big picture" of what will need to be prioritized by the receiver of the handoff)?	Yes	No

Rate the frequency (checking the appropriate column below) with which the resident who gave the handoff did the following (IPASS):

	Description	Never	Rarely	Sometimes	Usually	Always
Illness Severity (I)	Identification as stable, "watcher", or unstable, identify whether DNR					
Patient Summary (P)	Brief hospital course, new/recent events, overall clinical status using the standardized patient summary					
Action Plan (A)	Task list for overnight complete with plan *(i.e. if hemoglobin below 7, transfuse 1 unit PRBC)*					
Situation Awareness/ Contingency Planning (S)	Anticipate upcoming possibilities and provide anticipatory guidance *("if X then Y" statements)*					
Ensures synthesis by receiver (S)	Actively engages receiver to ensure shared understanding of patients *(Encouraged questions, checks for understanding)*					
Triage/Prioritize	Appropriately prioritizes key information, concerns, or actions					

Rate the frequency with ehich the resident who gave the handoff did the following:

	Never	Rarely	Occasionally	Fairly Often	Very Often	Unable to Assess
Miscommunications or transfer of erroneous information						
Omissions of important information						
Tangential or unrelated conversations						

Rate the written handoff (EPIC Handover Tool):

	Never	Rarely	Occasionally	Usually	Always	Unable to Assess
Was the information in the written handoff UPDATED and ACCURATE?						
Were there omissions of key information from the written handoff?						

Rate the overall impression of the pace of the handoff (circle one):

Very slow & Very inefficient	Slow and inefficient	Optimally paced Efficient Not rushed	Fast and Pressured	Very Fast & Very Pressured

Overall feedback (what was good about the handoff, what areas could the resident work to improve?)

Attempt # _____ **Pass (Y/N)?** _____ **Attending Signature** _____

Note, if there is a check in any shaded box, the intern is not yet proficient in the skill and therefore will require further practice and re-evaluation

APPENDIX F: PATIENT GLOBAL ASSESSMENT FORM

Dear Patient,

Please give us feedback about your doctor visit today.

Circle the number that corresponds to your answer for each question on this survey.

Your responses are entirely confidential.

Thank you for your time. Your responses are valuable to us!

Please rate how well your doctor did in the following areas:	**Poor**	**Fair**	**Good**	**Very Good**
Listened to what you had to say?	1	2	3	4
Showed concern for your questions and worries?	1	2	3	4
Explained your health/condition in words you could understand?	1	2	3	4
Explained medications and tests?	1	2	3	4
Included you in decisions about your treatment?	1	2	3	4
Was friendly and caring?	1	2	3	4
Washed their hands or used hand sanitizer (circle one)?	Yes		No	

Comments:

APPENDIX G: STAFF GLOBAL ASSESSMENT FORM

Resident: _____ **PGY Level (circle):** 1 2 3 **Date:** ___/____/_____

Please check the column that best describes this resident's performance in each performance item.

It is helpful to include comments that explain your answers in order to give this resident constructive feedback.

Performance Areas	***Unsatisfactory***	***Needs Improvement***	***Meets Expectation***	***Exceeds expectations***	***Not applicable***
Attends to patient's comfort and understanding during visit and any procedures performed.					
Receptive and uses feedback from staff to improve patient care.					
Communicates with staff in a manner that is both effective and respectful.					
Demonstrates sensitivity to a diverse patient population.					
Actively listens to patient and staff concerns.					
Behaves in a sympathetic and caring manner with patients and families.					
Respond to questions in a timely manner.					
Effectively coordinate patient care by considering input from all team members.					
Comments:					

APPENDIX H: ACLS CODE COMPETENCY CHECKLIST

UT Erlanger Internal Medicine ACLS Competency Checklist

Name _____

Simulation Date _____

PGY Level _____

Observers_____

Skill	Performed?	Comments
Team Leader		
Assign roles		
Ensures high quality CPR		
VF/VT Arrest		
Recognize VT		
Recognize VFib		
Defibrillation delivered at appropriate intervals		
Resume chest compressions immediately after defibrillation		
Appropriate management of airway (BVM)		
Appropriate administration of epinephrine (after 2rd defibrillation)		
Appropriate administration of amiodarone (After 3nd defibrillation)		
Asystole and PEA management		
Recognize PEA		
Recognize asystole		
Appropriate administration of epinephrine (every 3-5 min)		
Verbalize reversible causes of PEA arrest		
Post Cardiac Arrest Management		
Recognize ROSC		
Check vitals, order labs, transfer to ICU		

Comments:

Total Score _____

For passing, requires 12 out of 15 points.

APPENDIX I: INTERPROFESSIONAL EVALUATION FORM

Please provide any examples that pertain to the descriptions below for any of the listed milestone assessments for the medical resident, Dr. _____.

Often times, factors beyond the acute medical illness affect patient care. Please provide examples of how the resident recognized the role of income, social support, and behavioral factors on the patient's care (MK1):	
Examples:	
Please describe how the resident involved your specialty in the decision making for the patient's care (SBP1):	
Examples:	
Please provide examples of how the resident identified opportunities to prevent or respond to error for a particular patient or within the healthcare system (SBP2):	
Examples:	
Describe how the resident limited unnecessary cost through mechanisms such as – use of generic or formulary alternative medications, drug assistance programs, avoidance of unnecessary testing and treatment, or avoiding emergency room care for patients experiencing acute illnesses that can be managed as an outpatient (SBP3):	
Examples:	
Please provide examples of the resident's skill(s) at transitioning patients between hospital units as well as to home. This may relate to medication reconciliation, consideration of future care, or navigation of safe-discharge barriers such as transportation, ability to purchase medications, home living environment, language/cognitive barriers, or social support (SBP4):	
Examples:	

Please describe when you gave feedback to the resident in terms of their openness and acceptance, and if you noticed they reflected on your comments and made changes leading to improvement (PBLI3):	
Examples:	
Summarize ways you found the resident displayed empathy and advocated for their patients, noting the resident's respectful, professional, and compassionate interactions (PROF1):	
Examples:	
Please provide examples of how the resident was (or wasn't) timely in the completion of tasks you requested. Please comment if the resident needed multiple reminders (PROF2):	
Examples:	
Please comment on specific times you noticed the resident considered the patient's culture, beliefs, impact of their illness, etc. in the patient's plan of care (PROF3):	
Examples:	
Please state if the resident was (or was not) approachable, collaborative, and/or accepting of your input to the care of the patient (ICS2):	
Examples:	
Please feel free to provide any additional comments you think are germane to the aspects of this assessment instrument:	

APPENDIX J: TEACHING 101 - TIPS FOR TEACHING MEDICAL STUDENTS

Asking Questions

Ask yourself do you want your learners to learn concepts or factoids? If its concepts, you should ask questions accordingly (i.e., don't ask factoids). Like good interviewing skills, good teaching skills entails open-ended questions, so you can better assess your student's and intern's learning needs, to help them gain confidence in their knowledge as they answer your questions, and to help them reason to the correct answer, rather than "read my mind" questions or guess these esoteric questions. For example, let's say a patient is admitted with hypertensive emergency, was placed on a nitroprusside drip, then weaned from that and now transferred to the floor.

---Example of a factoid question: "Prolonged administration of nitroprusside can result in what type of poisoning?" (Cyanide)

---Example of a pretty good open-ended question: "Can you tell me the difference between hypertensive emergency and hypertensive urgency?"

---Even better open-ended question: "Tell me what you know about hypertensive emergency?"

The reason the last one is better is that for the first two questions, they will need to recite a factoid (question 1) or for question 2, would need to have some concept of urgency vs. emergency to answer the question. For the third question, they can just tell you what they know, and this can allow you to know what to teach, and to prompt them to reason to an answer. For example, the student may know all about hypertensive emergency, and reciting their knowledge on rounds is a great confidence builder for them and makes them a part of the team teaching. But say they say they don't know about hypertensive emergency. Your teaching options now are to wax eloquent yourself, or better yet, force them to reason: "Well, let's think…what would be an emergency situation with high blood pressure"; or if they are more novice: "Hypertensive emergency is a situation where there is end-organ damage from the high blood pressure. What are some organs which might be damaged? Yes, the heart, they may have a heart attack, what else? Yes, the brain…." etc.

Fastballs

Early in the month your students and interns are often a little nervous and unsure. My first questions of the month, and usually my first questions each day, are relatively easy, to help them build confidence in answering questions in front of an audience ("Tell me what you know about heart failure").

Limits

A common mistake for novice teachers is, that in their excitement to teach everything they know, they never let a teaching moment go by. Certainly, powerful teaching moments need to not be missed, but the powerful ones are usually in the context of the patient (such as an intense discussion with a patient or family; or sometimes, explicit description of how you arrived at a clinical decision). However, many topics come up time and time again on the wards (CHF, PE, COPD, etc.), and each of these conditions only has so many teaching

points. There is no reason to drown rounds with too many teaching points – try to limit it to 5-10 major points per day at most.

Plan

Many people approach teaching in a reactive fashion, the student or intern mentions something, a light bulb goes off as far as a question to ask in that situation, and so it goes. Certainly, this reactor method is preferable to no teaching at all. But a risk of the reactor method is that you will drown rounds in too many facts, rounds won't be efficient, and further, your teaching will be limited to what is mentioned by the student or intern – important topics won't be broached. Better yet, you know the patients on your team ahead of time so plan for at least some of the points you are going to make on next day's rounds.

A corollary to this is planning prior to seeing a patient. For example, if your focus of teaching is doctor-patient communication, one can usually anticipate intense discussions before you walk into the room. Ask the students and residents how they want to approach this situation (say a patient who is ready for discharge, but is scared to leave the hospital). Then once discussed, model it (either you or your designee). AND THEN, reflect on what happened after the discussion, when you leave the room.

Reflect Aloud

To really make a teaching point stick, you need to reflect on what happened. You need to do this explicitly, aloud, so the students and interns can follow your reasoning and understanding. For example: "You see why we chose to empirically anticoagulate this patient with a suspected PE (until the CT or V/Q scan was finally done), he had all the risk factors for DVT…."; or if things go bad: "Looking back, you need to reflect on your decisions, and this patient did have a GI bleed after we empirically anticoagulated him for PE, was this the right decision, ……". We all reflect on medical decisions in our minds; for your learners, simply reflect aloud.

Think Out Loud

If you're making a complicated decision (say, not to give or to discontinue antibiotics for a patient with fever but no obvious infectious source), think out loud your decision process. Even if the decision seems straightforward, check your learner's understanding of the plan – "Do you understand why we're getting an ERCP for this patient with jaundice?"

It's Okay to Say "I Don't Know"

No one knows everything, so don't be fearful if you can't answer all of your learner's questions. By saying "I don't know, but I'm going to learn about this…." (or better yet, why don't WE all learn about this), you are not modeling inadequate knowledge, you are modeling lifelong learning.

Teach Your Self

The most lingering thing you will teach your students is yourself, the way you comport yourself, the way you ARE as a doctor and a person.

APPENDIX K: RESIDENT PERFORMANCE EXPECTATIONS

The following is an important description of the competency and milestone expectations for residents at different levels of training based on the six core competencies. These learning objectives are collected for the convenience of our residents and faculty and are intended to allow for rapid review of expectations at different levels of training. Please note that the stated objectives should never limit our achievement expectations. Residents at all levels of training should strive to continuously improve their competency in the diverse skills that define excellence for internists.

PGY-1

Patient Care

Inherent in good patient care is a resident's ability to demonstrate integrity, respect, compassion and empathy for patients and their families. Residents at all levels of training will demonstrate sensitivity and responsiveness to patient's age, culture, gender and disabilities.

PGY-1 residents will:

- Gather essential and accurate information.
- Organize and record medical information accurately.
- Synthesize and interpret data from other providers and diagnostic testing.
- Develop skills of focused history taking based on the established diagnosis or differential diagnosis.
- Perform complete physical exams with consistent sequence.
- Describe and interpret abnormal findings.
- Identify problems and prioritize the differential diagnosis.
- Begin to formulate clinical plans of action that are guideline or evidence-based.
- With experience, develop the appropriate use of diagnostics and therapeutic choices.
- Begin to prioritize the care of unstable patients.
- Address acute and chronic problems, as well as addressing issues of prevention and health promotion.
- Demonstrate an understanding of the indications, contraindications and techniques for procedures.
- Participate in informed consent with patients.
- Be supervised for all procedures until clinical competency is achieved.
- Clearly document all procedures.

Medical Knowledge

At this level of professional development most learning is self-directed. It is advised that residents read daily and teach daily the things that they are learning. A spirit of intellectual curiosity and scientific inquiry is desirable. Residents must demonstrate knowledge about established and evolving biomedical sciences, clinical care topics and the social sciences.

PGY-1 residents will:

- Demonstrate knowledge of common medical conditions and procedures.
- Demonstrate satisfactory management of common conditions with minimal supervision by completion of PGY-1 year.
- Take the In-Service Training exam.
- Actively participate in the Yale Office Based Curriculum embedded in the ambulatory curriculum.
- Begin and progress towards completion of required IHI modules as stated in the program manual.
- Attend all required conferences.
- Demonstrate level-appropriate competence in interpreting diagnostic EKG's, pulmonary function testing, common radiologic studies, lab medicine, including hematologic, infectious, chemical and microscopic diagnostic studies.
- Pass the USMLE Step 3/COMLEX Level 3 exam by March 30.

Interpersonal and Communication Skills

Residents at all levels of training should be able to do the following:

a. Articulately present full histories and physicals.
b. Summarize relevant aspects of history, physical, diagnostic testing and assessment and plan.
c. Should welcome, mentor and teach learners of all levels.
d. Display empathy and competence while interviewing and examining patients.

PGY-1 residents will:

- Provide complete and accurate documentation of patient care that is legible and timely.
- Demonstrate appropriate verbal and nonverbal skills in patient and colleague interaction.
- Respect appropriate boundaries of patients and colleagues that follow the tenets of ethics in patient care and professionalism.
- Show ability to work in teams with junior and senior colleagues, attendings, students, nurses and social workers.
- Supervise, teach and give constructive feedback to students.

Practice-Based Learning and Improvement

Residents are expected to be intellectually curious. They should use patient care experiences, reading and evidence-based medicine as a foundation for practice improvement and lifelong learning. Residents should understand the limits of their knowledge and experience and ask for help when needed. Self-improvement comes from regular assessments of all competencies and receiving balanced and honest feedback.

PGY-1 residents will:

- Show motivation to learn.

- Use medical literature to support decision-making.
- Begin skills of:
    - Asking relevant and accurate clinical questions.
    - Understanding the difference between background and foreground information.
    - Efficiently using technology to access the medical literature.

Professionalism

This competency is difficult to define by level of training. There are many qualities and characteristics that are fundamental to the practice of medicine. All physicians must be competent. This includes being timely in regard to patient care needs. In work related activities, patient care must always come first. Intrinsic to the competency of Professionalism is honesty/integrity. Residents at all levels should be trustworthy and should tell the truth. This includes: 1) in reporting and presenting patient communications 2) documentation 3) admitting areas of deficiency and 4) billing. The practice of medicine has historically been synonymous with a spirit of compassion and respect for others. A resident's attitude should manifest an interest in helping their patients, demonstrating respect and compassion for all patients and understanding the need for patient confidentiality. Physicians also have a responsibility for the safety and well-being of their patients, colleagues and staff. Residents should not be unduly influenced by any outside forces including the pharmaceutical industry, insurers or patients' families. Under no circumstances should the quality of care, nor the specific care offered, be unduly influenced by these outside forces.

Systems-Based Practice Objectives

Modern medicine is practiced in a complex series of interwoven systems including insurers, hospitals, health care providers, private and public practitioners and the legal system. The residents must demonstrate an awareness of the larger context and system on health care delivery and the ability to effectively call on system resources to provide care that is of optimum value.

The PGY-1 resident will:

- Demonstrate the ability to work well within their core clinical team.
- Participate in multidisciplinary rounds utilizing the different services (nursing, social work, respiratory therapy, physical therapy, case managers, etc.) to improve efficiency and patient outcomes.
- Show understanding of cost-effective patient care and resource utilization.
- Participate in evaluation of the systems we work in to improve patient outcomes, efficiency and physician satisfaction; this would include reporting events into the eSafe database.

PGY-2

Patient Care

In addition to the PGY-1 objectives, PGY-2 residents will:

- Improve on the interpretation of history and improve their efficiency.
- Correctly detect subtle findings on physical exam.
- Teach physical exam skills to peers and students.
- Incorporate patient preference, cost, and risk and benefit when considering specific treatment and diagnosis.
- Change the course of care for unexpected side effects or undesired outcomes of a treatment plan.
- Supervise junior residents in procedures when competency has been achieved.
- Improve procedural skills through repetition.
- Minimize risk and discomfort of patients.

Medical Knowledge

In addition to the PGY-1 objectives, PGY-2 residents will:

- Demonstrate improved knowledge and analytical thinking in complex patients.
- Demonstrate understanding of psychosocial issues, statistical analysis and their application to patient care.
- Show evidence of continued reading and improvement in medical knowledge.
- Present at an M & M/Patient Safety Rounds.

Interpersonal and Communication Skills

In addition to the PGY-1 objectives, PGY-2 residents will:

- Engage patients in difficult discussions (examples include end-of-life-care) and successfully negotiate with “difficult” patients.
- Evaluate and give constructive feedback to junior team members about their presenting skills.
- Successfully manage, take charge and coordinate care when they are the senior resident on an inpatient team. This includes setting expectations, encouraging academic discussions and insuring that patients are well informed about their medical conditions and clinical plan of action.
- Communicate clearly with team members, consultants, primary care physicians, patients and families.

Practice-Based Learning and Improvement

In addition to the PGY-1 objectives, PGY-2 residents will:

- Demonstrate an understanding and use of an evidenced-based medicine approach in providing patient care.
- Teach colleagues and students how to research relevant literature.
- Display self-initiative to stay current with new medical knowledge.
- Use consult time to practice integrating evidenced-based medicine with expert opinion and professional judgment.

Professionalism

In addition to the PGY-1 objectives, PGY-2 residents will:

- Continue to improve their knowledge with self-directed learning.
- Improve in their ability to deliver bad news.
- Understand the patient care issues involving advanced directives, DNR status, futility, withholding or withdrawing care.
- Show appropriate sensitivity to issues of culture, age, sex, sexual orientation and disability.
- Show concern for the educational development of colleagues and students.
- Provide leadership on teams and throughout the residency.
- Volunteers for activities that are good for the community and the institution overall.

Systems-Based Practice Objectives

In addition to the PGY-1 objectives, the PGY-2/3 will:

- Coordinate multidisciplinary care and provide leadership in the management of complex patients.
- Demonstrate an understanding of the multi-layered medical delivery systems (including hospitals, ambulatory sites, rehab medicine, and in-home care resources).
- Show the ability to work with extended care providers, especially with longitudinal chronic care in the outpatient setting.
- Demonstrate an understanding of managed care, federal versus private insurers and the social consequences of the uninsured.
- The resident will participate in a root-cause analysis.

PGY-3

Patient Care

In addition to the PGY-1 and PGY-2 objectives, PGY-3 residents will:

- Appropriately conduct focused exams.
- Demonstrate sound reasoning in ambiguous situations.
- Assist junior residents/students in improving skill of effective decision-making.
- Serve as lead provider on the RRT/Code service.

Medical Knowledge

In addition to the PGY-1 and PGY-2 objectives, PGY-3 residents will:

- Exhibit knowledge and competency of effective teaching methods.

Interpersonal and Communication Skills

In addition to the PGY-1 and PGY-2 objectives, PGY-3 residents will:

- Be able to negotiate most difficult patient situations with minimal direction
- Function as team leaders with decreasing reliance upon attending physicians.
- Develop skills for effective public speaking and teaching.
- Demonstrate the ability to articulate/advocate for issues of ethical concern, quality improvement, and patient safety.

Practice-Based Learning and Improvement Objectives

In addition to the PGY-1 and PGY-2 objectives, PGY-3 residents will:

- Apply knowledge of study design and statistics to relevant literature.
- Present a thoroughly researched didactic presentation that demonstrates an in-depth knowledge of a clinical topic of their choosing.
- Show mastery of the use of technology and its applications to patient care, acquisition of medical knowledge and educational presentations.

Professionalism

In addition to the above noted objectives, the PGY-3 resident will:

- Show leadership in improving all of the above noted activities personally and in mentoring that with their colleagues.
- The most experienced resident class sets the tone of the training experience for all residents. It is desirable that senior residents work hard at setting a high standard, enjoy their work, and bring that enthusiasm to their profession.

Systems-Based Practice Objectives

In addition to the PGY-1 objectives, the PGY-2/3 will:

- Coordinate multidisciplinary care and provide leadership in the management of complex patients.
- Demonstrate an understanding of the multi-layered medical delivery systems (including hospitals, ambulatory sites, rehab medicine, and in-home care resources).
- Show the ability to work with extended care providers, especially with longitudinal chronic care in the outpatient setting.
- Demonstrate an understanding of managed care, federal versus private insurers and the social consequences of the uninsured.

APPENDIX L: ADMINISTRATIVE TASKS COMPLETION POLICY

Accountability is one of the professionalism core competencies that residents must demonstrate during their residency (PRO 3). Throughout the academic year, there are mandatory deadlines that must be met. These are expectations of the Internal Medicine Residency administration, Department of Medicine, and Graduate Medical Education. Failure to meet any one of these deadlines will result in a warning from the Chief Resident. An additional failure will result in placement on to a Performance Improvement Plan (PIP). If deadlines continue to be missed the resident will be at risk for termination. This is a list of core deadlines expected by the program. Please note that other deadlines and tasks may come up throughout the academic year that may be equally essential.

Task	Expectation
Direct Observations Forms	Interns - 2 outpatient & 2 inpatient evaluations by December 31 Residents - 1 outpatient & 1 inpatient evaluation by March 30 Everyone – 1 handover by March 30
Duty Hours Logging in New Innovations	Weekly (and no more than 5 days without logging any hours)
ACLS/BLS Certification	Remains active without any lapse in certification
All assigned UTHSC Activities (including training modules, annual compliance modules, and Resident as Educator modules)	Per email deadlines from UTHSC
Annual Vacation/Leave Requests	July 15
Personal Day Requests	Must be requested 2 weeks in advance. For a clinic cancellation a period of 6 weeks is preferred. All remaining personal day requests for the year must be received by March 30.
MKSAP Questions	Last calendar day of each month
New Innovations Evaluations	Last calendar day of each month
USMLE Step 3 or COMLEX Level 3	Registered by Feb 28 of PGY-1 year with result back by July 1

APPENDIX M: GME MEDICAL/PARENTAL/CAREGIVER LEAVE FORM

THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER

GME Medical/Parental/Caregiver Leave Request Form

Section 1: Employee Information

Resident/Fellow Name: _____ Personnel #: _____

Program Name: _____ PGY Level: _____

Resident/Fellow Email Address: _____ Resident/Fellow Phone: _____

Section 2: Leave Information

Type of Leave: Medical ☐ Parental ☐ Caregiver ☐

Requested Medical/Parental/Caregiver Leave Dates:

Start Date: _____ End Date: _____ Weeks: _____

Are you taking additional annual and/or sick leave? Yes/No
If so, please indicate what type and the dates:

Type_____ Dates_____

Type_____ Dates_____

Hospital Rotation Location(s) During Leave: _____

I understand that in the case of an unexpected start date I should notify my Program Manager, Program Director, and Chief Resident (if applicable) as soon as possible.

Section 3: Program and Training Responsibilities

Resident/Fellow Signature: _____ Date: _____

Approved by: _____ Date: _____
Program Director

Potential training extension due to ACGME or ABMS requirements have been discussed.

_____ _____
Program Director initials Resident/Fellow initials

For Office Use Only:

This form should be turned into your Program Coordinator as soon as the Program Director has approved the leave. The Program Coordinator is responsible for notifying GME of the approved leave as soon as this form is received.

Coordinator Task (Required):

Enter dates into New Innovations with duty type "Leave – Parental/Caregiver" marked.

Scan form to GME at gme@uthsc.edu.

ACKNOWLEDGMENT OF MANUAL RECEIPT AND COMPREHENSION OF CONTENTS

I have received and read the Policies and Procedures and Graduation Requirements of the Department of Medicine. I understand the policy for advancement and graduation from the Residency Program.

_____

Signature

_____

Print Name

_____

Date

Please return by June 30, 2024 to Ms. Fuller.