



Internal Medicine Residency Program Housestaff Manual

Revised May 08, 2017

The Housestaff Manual is a guideline for the rules and regulation of the Internal Medicine Residency Program. The Manual will be updated on a periodic basis as the program continues to evolve. Residents will be emailed notification of updates and the Manual can be viewed on the programs Google Drive account. Questions about the policies outlined above can be directed to the Chief Residents.

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Important Websites

Residency Program <http://residency.medicine.ufl.edu/>
Benefits <http://adminaffairs.med.ufl.edu/fringe-benefits/housestaff-benefits/>
Graduate Medical Education <http://gme.med.ufl.edu/>
UF Health Science Center Library <http://www.library.health.ufl.edu/>
UF Health Bridge <https://bridge.ufhealth.org/>

Educational Goals of the Training Program

1. Train future physicians to become lifelong learners and future leaders in clinical practice, education, research, and/or administration.
2. Provide an intensive educational environment with a diversity of clinical settings to promote progressive responsibility, graduated autonomy, and team-based collaborative care.
3. Offer a versatile training program with various educational tracks and electives to cater to residents' individualized learning needs and career passions.
4. Educate residents in the principles of high value care, health care disparities, and population health management.
5. Engage residents in quality improvement/patient safety initiatives and scholarly research activity.
6. Maintain a culture of wellness and esprit de corps where resident support, camaraderie, and mentorship are top priority.

University of Florida Department of Medicine Duty Hour Policy

The ACGME defines duty hours as all clinical and academic activities related to the training program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site. In accordance with ACGME rules and regulations the Department of Medicine has set forth the following rules to regulate both its residency and fellowship training programs:

1. All Residents and fellows will receive one day off in seven when averaged over a four-week period. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
2. Trainee duty hours will be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Any hours spent during home call involving clinical duties will also be counted towards the 80 hour limit. Moonlighting done in the sponsoring institution counts toward the weekly limit.
3. Continuous on-site duty will not exceed 24 consecutive hours. Trainees may remain on duty for up to four additional hours to participate in transfer of patient care and/or to maintain continuity of medical care. During these four additional hours the trainee will not be responsible for the workup, admission, or care of a new patient. There must be at least 14 hours free of duty after 24 hours of in-house duty.
4. In-house call takes place no more than once every three nights (when averaged over a four-week period). Trainees will not be scheduled for more than six consecutive nights of night float.
5. There will be a 10-hour duty-free period (absolute minimum of 8 hours) between clinical duty periods, including post-call.
6. Moonlighting must be pre-approved by the Program Director in writing and is restricted to PGY-2 residents in the second half of the year and PGY-3 residents in good standing within the Program. Please see Section IX for the Moonlighting Policy.

The purpose of these duty hour rules is to ensure that the learning objectives of the program are not compromised by excessive reliance on Residents and fellows to fulfill service obligations.

At this time the ACGME rules which govern Internal Medicine training programs do not allow duty hours exceptions.

Work Hour Log Policy

The ACGME has established an 80-hour work week to ensure good patient care and adequate time for physician rest periods. The Department of Medicine utilizes a New Innovations computer system (webpage: <http://www.new-innov.com/login.htm>) to enable up-to-date monitoring of our Residents' work hours. The residency program monitors work hours to ensure compliance with the 80-hour work week and to ensure no rotations put undue demands on Residents.

Completing weekly work hour logs in the New Innovations system is a **requirement** of the residency program. Failure to do so in a timely manner is considered unprofessional behavior. As with all unprofessional behavior, Residents who do not complete weekly work hour logs may be subject to disciplinary action by the Housestaff Evaluation Committee (please refer to *Discipline Policy*, page 58).

The following policy is in place to ensure timely completion of work hour logs:

1. Work hour logs of the previous week must be completed **weekly**.
2. **Two Weeks Late:** Any Resident who has not yet completed two weeks of work hour logs will be given an electronic reminder notice via email.
3. **Three Weeks Late:** Any Resident who has not completed three weeks of work hour logs will be sent a hard copy letter of warning that will be sent to their Department of Medicine mailbox and placed in their Resident file.
4. **Four Weeks Late:** Any Resident who has not completed four weeks of work hour logs is subject to further disciplinary action, including assignment to Friday Night coverage or being pulled from their rotation to complete their logs. If needed for coverage, a backup Resident may be called in; the delinquent Resident **must** pay back this time to the covering Resident.

Resident Job Descriptions

PGY-1 (Intern)

POSITION SUMMARY: The Internal Medicine Intern shall function under the supervision of the attending medical staff. Often there will be an upper level Resident or fellow in a supervisory role as well. The Intern assists with admissions, consultations, evaluations, diagnosis and treatments of hospital and ambulatory patients. He/she may provide verbal, written and telephone orders.

PROCEDURES: The following procedures must be performed under the supervision of a practitioner with clinical privileges for the procedure, a fellow or an upper level Resident competent in the procedure. The procedures must be supervised until the Intern meets the requirements for performance of the procedure without direct supervision. In order to perform a procedure without direct supervision, an intern must complete that procedure under direct supervision at least 5 times.

Abdominal Paracentesis

Arthrocentesis

Arterial Puncture

Biopsy of Skin

Cardiopulmonary Resuscitation/Advanced Cardiopulmonary Life Support

Central Venous Placement

Genital Examination, Male
Lumbar Puncture
Pelvic Examination
Nasogastric Tube Insertion
Soft Tissue Injections
Thoracentesis
Vaginal Wet Mount Evaluation
Ventilator Management

QUALIFICATIONS: Must be able and willing to establish and maintain effective working relationships with patients, families, hospital staff, attending physicians and the public; and perform high-level decision-making.

EDUCATION: Doctor of Medicine (MD), or Doctor of Osteopathy (DO) or equivalent

LICENSURE and CERTIFICATION: Current Florida training license

EXPERIENCE: Medical degree

OTHER KNOWLEDGE and SKILLS: Commensurate with degree, advancement and responsibilities

DEMANDS: High level decision-making; performs highly complex and varied tasks

PHYSICAL DEMANDS: Ability to perform physical examination of patients; Dexterity needed to perform physical examination and procedures

EQUIPMENT: Demonstrates competency and dexterity with all equipment utilized in the hospital and ambulatory environment

RELATIONSHIPS: Reports to the Internal Medicine Residency Program Director at the University Florida and adheres to policies and procedures of the University of Florida Internal Medicine Residency Program.

SUPERVISES: Medical students, occasionally PA students

INTERNAL RELATIONSHIPS: Fellow Residents, residency program faculty and staff, hospital staff, and medical staff

EXTERNAL RELATIONSHIPS: Patients and families, and referring physicians

ESSENTIAL JOB FUNCTIONS:

- Develops and maintains a personal program of self-study and professional growth with guidance of the Internal Medicine Residency faculty
- Admission, consultation, evaluation, diagnosis and non-surgical treatment of patients with general medical problems. Provides safe, effective and compassionate patient care under supervision
- Demonstrates dexterity and competency to perform all essential and required procedures and provides complete, written documentation of all procedures
- Identifies need for patient education and orders or provides education
- Comprehensively documents in patients' charts in a timely and accurate manner.
- Demonstrates awareness and sensitivity to patient and family issues, including age, gender and

- cultural diversity
- Functions with an awareness and application of standard operating procedures including OSHA, HIPAA
- Efficiently performs in emergency situations, including adherence to established clinic and hospital-specific protocols
- Demonstrates applied knowledge base including integration of skills as required through block rotation experiences
- Provides teaching, supervision and serves as a role model to medical/PA students
- Participates actively in all educational and residency program activities and assumes responsibility for teaching other Residents and medical students
- Demonstrates awareness and applies knowledge of legal issues in all aspects of patient care, incorporating risk management skills, and quality control measures
- Actively participates on any assigned hospital committee as a member
- Demonstrates ability for effective problem identification and resolution as well as the exercise of independent judgment Participates in research and scholarly activities
- Demonstrates effective communication skills
- Participates in the resolution of Residents' staffing conflicts and maintains flexibility regarding staffing patterns, including on-call schedule and daily schedules
- Performs such duties as assigned by the Internal Medicine Residency Program Director, in accordance with the description of the Residency, to the best of his/her ability and under the highest personal bond of professional morals and ethics.
- Provides coverage for temporary staffing conflicts of the Residency program

PGY-2 and PGY-3 (Resident)

POSITION SUMMARY: The Internal Medicine Resident shall function under the supervision of the attending medical staff. On certain rotations there will be a supervising fellow as well. The Resident assists with admissions, consultations, evaluations, diagnosis and treatments of hospital and ambulatory patients. He/she may provide verbal, written and telephone orders.

PROCEDURES: The following procedures must be performed under the supervision of a practitioner with clinical privileges for the procedure, a fellow, or another upper level Resident competent in the procedure. The procedures must be supervised until the Resident meets the requirements for performance of the procedure without direct supervision. In order to complete a procedure without direct supervision, a resident must complete that procedure at under direct supervision at least 5 times.

Abdominal Paracentesis
 Arthrocentesis
 Arterial Puncture
 Biopsy of Skin
 Cardiopulmonary Resuscitation/Advanced Cardiopulmonary Life Support
 Central Venous Placement
 Genital Examination, Male
 Lumbar Puncture
 Pelvic Examination
 Nasogastric Tube Insertion
 Soft Tissue Injections
 Thoracentesis
 Vaginal Wet Mount Evaluation
 Ventilator Management

QUALIFICATIONS: Must be able and willing to establish and maintain effective working relationships with patients, families, hospital staff, attending physicians and the public; and perform high-level decision-making.

EDUCATION: Doctor of Medicine (MD), or Doctor of Osteopathy (DO) or equivalent

LICENSURE and CERTIFICATION: Current Florida training license

EXPERIENCE: Medical degree, successful completion of a PGY-1 year

OTHER KNOWLEDGE and SKILLS: Commensurate with degree, advancement and responsibilities

DEMANDS: High level decision-making; Performs highly complex and varied tasks

PHYSICAL DEMANDS: Ability to perform physical examination of patients; Dexterity needed to perform physical examination and procedures

EQUIPMENT: Demonstrates competency and dexterity with all equipment utilized in the hospital and ambulatory environment

RELATIONSHIPS: Reports to the Internal Medicine Residency Program Director at the University Florida. Adheres to policies and procedures, stated and published, of the University of Florida Internal Medicine Residency Program.

SUPERVISES: Interns, Medical students, occasionally PA students

INTERNAL RELATIONSHIPS: Fellow Residents, residency program faculty and staff, hospital staff, and medical staff

EXTERNAL RELATIONSHIPS: Patients and families, and referring physicians

ESSENTIAL JOB FUNCTIONS:

- Develops and maintains a personal program of self-study and professional growth with guidance of the Internal Medicine Residency faculty
- Admission, consultation, evaluation, diagnosis and non-surgical treatment of patients with general medical problems. Provides safe, effective and compassionate patient care under supervision
- Demonstrates dexterity and competency to perform all essential and required procedures and provides complete, written documentation of all procedures
- Identifies need for patient education and orders or provides education
- Comprehensively documents in patients' charts in a timely and accurate manner.
- Demonstrates awareness and sensitivity to patient and family issues, including age, gender and cultural diversity
- Functions with an awareness and application of standard operating procedures including OSHA, HIPAA
- Efficiently performs in emergency situations, including adherence to established clinic and hospital-specific protocols
- Demonstrates applied knowledge base including integration of skills as required through block rotation experiences

- Participates actively in all educational and residency program activities and assumes responsibility for teaching other Residents and medical students
- Demonstrates awareness and applies knowledge of legal issues in all aspects of patient care, incorporating risk management skills, and quality control measures
- Actively participates on any assigned hospital committee as a member
- Demonstrates effective communication skills
- Participates in the resolution of Residents' staffing conflicts and maintains flexibility regarding staffing patterns, including on-call schedule and daily schedules
- Provides coverage for temporary staffing conflicts of the Residency program
- Demonstrates ability for effective problem identification and resolution as well as the exercise of independent judgment
- Participates in research and scholarly activities
- Provides teaching, supervision and serves as a role model to other Residents.
- Performs such duties as assigned by the Internal Medicine Residency Program Director, in accordance with the description of the Residency, to the best of his/her ability and under the highest personal bond of professional morals and ethics.

Rotation Goals and Objectives

As per RRC requirements, all rotation Goals and Objectives must be reviewed at the start of each new rotation. All of these Goals and Objectives are also located online on the Residency Program's Google Drive account under "*Goals and Objective*." This is to open a dialog regarding expectations, schedule, and educational opportunities of the rotation. Any elective listed without an official Goals and Objectives description **will not be available for the rotation until one is completed**. If you are interested in rotating on such an elective, please see the Chief Residents at least 2 months prior to starting that rotation.

Please refer to the Residency Program's Google Drive for available rotations and any updates to these documents throughout the remainder of your training.

If you have any questions or comments about these documents, or if you want to submit changes to them, please see any of the members of the Residency Program Administration or your Attending of Record.

Policy on Resident Stress & Fatigue

FATIGUED INDIVIDUALS tend to be in denial about their own functioning and will not always recognize it. Fatigue may be seen in someone who:

1. Has a poor attention span
2. Is easily distracted
3. Lacks interest/motivation
4. Appears depressed
5. Has impaired judgment
6. Seems excessively worried or anxious
7. Is socially withdrawn

THERE ARE FOUR MAIN CAUSES OF FATIGUE: Inadequate rest; desynchronized day/night cycles; weariness following physical activity; and impaired judgment following prolonged mental activity.

FATIGUE-INDUCED ERRORS include **errors of commission** (doing something incorrectly) and **errors of omission** (not doing something that should be done). Errors of omission are the most common errors

made by fatigued individuals.

IF YOU BELIEVE YOU ARE FATIGUED: The University of Florida maintains a supportive and non-punitive environment. If you believe that you are fatigued or if you observe another individual who is clearly fatigued, the following actions should be taken:

1. Immediately notify a Chief Resident and your supervising Resident/Attending.
2. Request that you be relieved from duty after assuring a smooth transition of patient care.
3. The Chief Resident will determine coverage requirement(s) depending on the circumstances.

ADDITIONAL RESOURCES: There are a number of available resources for Residents in need of help:

- Office of Graduate Medical Education provides confidential psychological and psychiatric services through the **Resident Assistance Program**. Residents may self-refer by calling (352) 265-5493 or 1-866-643-9375.
- Counseling services provided by the University Of Florida Department Of Psychology are covered by the house staff insurance plan.
- Arrangements may be made individually or through the Chief Residents to see dedicated faculty in the Department of Psychiatry.

Additional Monitoring

1. Peer-Directed: If one member of the housestaff team appears to be having difficulties, that individual or any member of that team can speak with the attending or Chief Resident.
2. Patient Care Resource Manager (PCRM): Many PCRM's have a background in social work and discussion is directed towards Residents' performance and well-being if there is concern about Resident stress or fatigue. The Department of Medicine Vice Chairman for Clinical Affairs and the UFH Chief Resident meet monthly with the Patient Care Resource Managers assigned to each inpatient floor.
3. Housestaff Advisory Council (HAC): The HAC meets monthly and is composed of the Program Director, Associate Program Directors, Chief Residents, Chief Resident-Elects, and two representatives from each PGY class (I and II). Resident representatives selected by their peers may bring any concerns to the attention of the Council.
4. Chief Residents: The Chief Residents maintain an open-door policy for any and all Resident concerns. The **Chief pager (413-4553)** can be reached 24 hours/7 days a week and ensures that one of the Chiefs is always available for any concerns. The Chief Residents and the program coordinator also monitor Resident work hours as an indicator of Resident stress, fatigue, and ACGME compliance.
5. Program Director: Dr. Edwards makes it a point to be available to address Resident concerns. Personal meetings may be arranged, or he may be contacted by phone (**265-0239**) or email at larry.edwards@medicine.ufl.edu to immediately address concerns.
6. Department Chairman: Dr. Hromas holds monthly meetings with the Residents at noon conference, usually conducted in an open forum to address Resident concerns. The Chairman's email address is robert.hromas@medicine.ufl.edu; Residents may also contact his office directly to schedule an

appointment with him.

7. House Staff Evaluation Committee: Each Resident has a committee member mentor, designated by the Program Director, who meets with them semi-annually to review evaluations, conference attendance, and procedure logs. Areas of concern the house staff may have about stress, fatigue, the program, future careers, or individual difficulties are confidentially discussed. The House Staff Evaluation Committee meets throughout the year to review any program issues that lead to undue stress so they can be evaluated and modified if necessary.

General Inpatient Policies

Days Off: All members of the team need to have **one day off in seven when averaged over a 4 week period, for a total of 4 days off per monthly rotation or 2 days off for a half month rotation.** At the beginning of each month, the team (including the students) should sit down and determine which day's team members will have off based on the call schedule. The attending should be involved in the decision of which days the Resident will have off. Ideally, Residents should have "golden days" or "early call" days off to permit Interns to have weekend days off. The day off must be free of clinical duties. Residents should give their pager or forward their pages to their attending or covering Resident on their day off. Interns should give their pager or forward their pages to the Resident on the team on their day off. If anyone is found to be engaged in patient care responsibilities on their day off, that day will not be counted, and another day off will have to be scheduled.

Ancillary Services: Residents are not required to routinely perform ancillary services such as phlebotomy, IV placement, transportation, or clerical duties. At both UF-Health and the Gainesville VA Medical Center these services should be available at all times when necessary. If Residents find themselves performing such duties that they find to be service without education, they must notify the Program Director or Chief Resident.

Conference Attendance: In addition to the learning that comes from working with attending physicians and consulting services in the care of the patients, other experiences will help form the basis for your residency education. **Attendance at conferences is mandatory and sign-in is required.**

Each Resident is expected to achieve **70% combined noon conference, grand rounds, board review (PGY-2 and 3 residents), & morning report attendance** throughout the duration of his/her training program.

Didactic Teaching Sessions

Nursing staff has been instructed not to page house staff during these conferences, unless it is an emergency. In these situations, the nurses are to tag the pagers with #911.

Morning Report:

Attendance is required at all Morning Reports.

- At UF-Health, the General Medicine Ward teams (Blue, Gold, Red, Green, and Orange) are expected to attend, as well as those on all inpatient electives, unless other conference or patient responsibilities prohibit this attendance.
- Those on the Ambulatory Block are expected to attend Morning Report on any day on which they are not scheduled for clinic.
- At UF-Health, the Oncology, Cardiology, and GI/Liver teams are expected to attend their

subspecialty teaching conferences.

- At the VA, the General Medicine Ward teams (Blue, Green, Orange, and Red) and the GEM team are expected to attend as well as those on all inpatient electives, unless other conference or patient responsibilities prohibit this attendance.

For Residents and Interns: At both UF-Health and the VA, Morning Report is held every Monday and Friday, from 8:00 a.m. to 8:45 a.m. The locations are the Medicine Library for UF-Health and UF Education Building at the VA. The morning report format for these days will vary from a traditional case presentation, Resident-directed learning or admission intake report. Tuesday and Wednesday Morning report are held jointly at UF-Health in the Medicine Library for both Interns and Residents. Topics covered at Morning Report on Tuesdays and Wednesdays vary but include Medical Jeopardy, Quality Improvement, Radiology Cases, Breakfast with the Chiefs, Journal Club, and others at the discretion of the chief residents.

Night Team: There is a Night Team Morning Report held on the 2nd and 4th Thursday mornings of the month starting at 7:15am at the Medicine Library at UFH. Both the UFH and VA Night Team are expected to attend. The discussions will include systems based problems which occur overnight at UFH and the VA when admitting or cross-covering patients. This is also a forum to provide feedback about any issues the teams are facing overnight. The Admissions Resident and Cross Cover Resident will have the opportunity to present any interesting/challenging cases seen during the rotation, and the work up and treatment of these patients will be discussed.

Noon Conferences:

The Resident and Interns are mandated to attend all scheduled conferences including Grand Rounds, M & M, and noon conference. While on the wards, a reminder to the attending that the noon hour is approaching is appropriate so that the team can attend the conference. Noon conference starts at 12:00 pm at UF Health in room 6120 on Monday, Tuesday, Wednesday, and Friday.

Grand Rounds:

Held every Thursday at 11:00 a.m. in C1-11 (Communicore Building).

Additional Educational Provisions

Senior Talks: Presenting a senior talk is required of all PGY-3's and fulfills a part of the ACGME requirement for scholarly activities. Topics should be on a clinical or basic science topic, preferably on a research or quality improvement project that the Resident has been involved with during his or her training. The senior talk should be approximately 30 minutes in length, and will be presented at noon conference to all house staff. Senior talks will occur in the spring. A list of dates will be provided by the Chief Residents; the Resident will provide the topic of the lecture when signing up for a date and this topic is subject to approval by the program director and his or her designees.

Board Review: The Board Review curriculum consists of review of MKSAP questions on a weekly basis. Specifically, 1 session is held per week following Grand Rounds on Thursdays from 12:00-1:00pm in the DoM (House staff) library. Attendance is required of all PGY-2's and PGY-3's unless you are at an off-site clinic, in the MICU/CCU, or on a night rotation. PGY-1's are encouraged to attend but are not required to do so.

In Service Exam: Each year Residents are expected to sit for the In-Service Exam provided by the American College of Physicians, usually occurring in October. All PGY-1's, PGY- 2's and PGY-3's are required to take this exam. If a Resident scores below the 40th percentile compared with peers on the same level, he or she will be required to participate in a remediation process involving the completion of

at least 100 board review questions monthly. In addition he or she may be asked to lead additional didactic teaching session and other activities at the discretion of the Chief Residents, Associate Program Directors, and the Program Director. **If the resident performs below the 30th percentile on this exam compared to peers at the same level he or she will not be allowed to participate in any moonlighting activities until improvement above the 30th percentile is shown on subsequent in-service exams.**

Dress Code Policy:

Clinic:

- Men – dress pants, collared shirt, tie; if you choose not to wear a tie then you must wear your white coat, no jeans
- Ladies – business appropriate skirt or pants with shirt/blouse or appropriate professional dress, no jeans
- Everyone – clean and well-groomed (comb your hair and keep facial hair neatly trimmed); don't wear excessive cologne or perfumes ; wear professional shoes and not tennis shoes in clinic

Inpatient

- Wards: Professional attire as above at all times whether at VA or UF Health during normal work hours (7a-5p, M-F)
 - Does not change with the call day
 - Weekends: Scrubs Permitted
- Consults/ Electives: Professional attire as above unless otherwise stated (ie EP Consults)
- Procedures: Professional attire as above
- Nights: Scrubs permitted
- MICU/CCU: Scrubs Permitted
- AOD/Bridge: Scrubs Permitted

Notes:

- Scrubs should be full scrub attire (do not wear t shirts, jeans combinations)
- Wear OSHA Compliant shoes (no sandals, no crocs)
- Med Students are held to the same standard

Attendance Policy

Attendance Policy: Overall conference attendance of 70% is required over the academic year which will be tracked using New Innovations. Those not achieving an average 70% attendance rate can be placed on Friday night coverage and/or back-up duty. The night of coverage will be decided upon by the Chief Residents and the currently scheduled Resident can be relieved of their Friday night duties.

Morning Report: Residents on inpatient general medicine teaching team, Elective and Ambulatory rotations and second week of EBM are expected to be at Morning Report. Attendance is expected unless urgent patient care issues are being addressed. Housestaff are urged to notify the Chief Resident(s) if there are barriers to Morning Report attendance.

Credit will not be given for attendance for individuals who arrive after 8:05am.

Noon conference: Residents on any rotation other than MICU, Nights, Vacation or currently scheduled in an Off-site clinic location are required to attend Noon Conference.

Credit will not be given for attendance for individuals who arrive after 12:10pm.

Credit will also not be given for attendance if a Resident leaves before the end of

conference. (Exceptions include leaving for clinic or a patient emergency.)

Board Review for PGY-3: For PGY-2 and PGY-3 Residents, attendance at weekly Board Review is mandatory.

Grand Rounds Attendance: Since it is the showcase conference of the Department, active attendance by Residents is essential. Attendance at Grand Rounds counts toward the overall conference attendance requirement for the program.

Additional Seminars/Learning Opportunities: Throughout the academic year, housestaff are offered the opportunity to participate in educational activities such as ACLS, Peer Review Committee, etc. If a member of the housestaff registers for this type of educational activity they are expected to attend. Failure to do so without prior notification to the Course Director or the Chief Resident may result in the assignment of additional clinical duties such as a Friday night shift.

Excused Absence from Conference: Residents on ICU, Nights, and Vacation will be excused from all conferences. Residents on AOD, VA MOD, ER, Elective with AM Clinics will be excused from Morning Report. All residents with AM clinic during elective/ambulatory will be excused from Morning Report. Residents on clinic elective outside of UF Health (Dermatology/Radiology/Sports Medicine) will be excused from respective conferences.

Bounce Policy for both UF Health and the VA:

Housestaff Associated Services: A “bounce” is a patient who is re-admitted to its previous team when the same Intern/Resident pair exists on service. This is independent of the attending physician. This policy ensures fairness to other medicine services as well as establishing some degree of continuity of care for patients cared for by the team. Bounces count as a new patient work-up and count towards team and individual caps. A bounce will be worked up by their original team under the following guidelines:

A. From **Monday through Friday**, General Medicine bounces will be worked up by the patient’s original team until 3 p.m., for the all teams including golden. From 3 p.m. to 7 p.m. the late call will admit the patient as a holding note to the previous team. This patient **WILL** count towards the late call team’s cap for admissions that day. **It is expected that all Residents/ Interns on any medical service will stay in house until 3 pm daily (weekdays)** in order to be available to admit bounces.

B. Any bounces coming back to their original team who happen to be on long-call that day will be worked up by that team until 7 p.m. If the bounce is within 72 hours, the patient will count toward the total team cap of 20, but will not count toward the admissions cap of 5. If the bounce is greater than 72 hours, the patient will count toward the total team cap of 20 **AND** the admissions cap of 5. Any general medicine bounces after 7:00 pm will be admitted by the night resident as a bounce to the original team. General Medicine patients who are “bounces” will not count towards the 2 (on Friday and Saturday) or 3 (Sunday through Thursday) “General Medicine” admissions. Those admissions will, however, count toward the total cap of 8 for the Night Team admitting Resident.

C. On the **weekends and official Holidays**, all teams must admit their own bounces until 12:00 p.m. (noon) at both UF Health and the VA. From 12:00 p.m. (noon) to 7:00 p.m., the late call team admits the bounce as a holding note to the patient’s original team. This bounce “holding note” will count toward the late call team’s cap for admissions that day. After 7:00 p.m., the Night Team admits the bounce to the original team. This admission will count towards the total cap of the UFH Night Resident and the total team cap of the receiving service the next day. The original team will assume care of the patient the following day at 7:00 a.m. in any of the scenarios above. It is, once again, **expected that the Residents remain in house until noon** in order to be available to admit these patients.

D. Subspecialty team bounces will be admitted by a member of that team until their admitting time ends for that calendar day. If an Intern from the team is admitting until 7:00 p.m., they must admit all bounces, including those who were followed by their fellow Intern. From the last admitting time until 7:00 a.m., the Night resident will admit bounces as holding notes to the original team. As always these admissions will count towards Night Team admission cap as well as the subspecialty team's total census cap.

E. Bounces do count towards the daily admission cap if that patient returns more than 72 hours from the previous discharge. If the patient was discharged less than 72 hours from time they presented again, then that patient counts **ONLY** towards the team's total census cap (e.g. 20 on general medicine) and not the Five daily admissions. For example: A late call service has 9 patients going into late call. During that admission day, a bounce returns less than 72 hours after discharge. That patient counts towards the total team cap of 20 but not the daily admission cap of 5. Thereby, the admitting team will admit **6** patients on that call day (**5 + 1 bounce**) since the bounce is less than 72 hrs since discharged.

Bounce Policy for Hospitalist Service:

For the Hospitalist Service at UF Health, a patient is considered a bounce if the patient was discharged within the last 72 hours. If a Hospitalist patient is transferred to the MICU or IMC, they will return to the Hospitalist service when they are transferred back out of the MICU or IMC within 72 hours. For the Silver, Gold, and Purple Hospitalist Services at the VAMC, a patient is considered a bounce if the patient was discharged within the last 72 hours *and* the same attending is on service. If a hospitalist service patient is transferred to the MICU, they will return to the hospitalist service when they are transferred back out of the MICU within 72 hours if the same attending is on service. **If a team reaches its cap of admissions or team census then overflow will be handled by the Hospitalist Service.** Backup is not to be called to admit these patients. Residents while working on service are **NOT** allowed to admit patients to the hospitalist service. For example, the resident AOD is not permitted to do admissions for the Hospitalist AOD during their shift.

Conflict Resolution Between Services:

Occasionally there may be instances when the primary medicine service is not satisfied with the quality of consultation provided by other services (such as surgical specialties and subspecialties, psychiatry, etc.). There also may be disputes between housestaff services. In these instances it is the PGY-2 or PGY-3 Resident's responsibility to contact the service to clarify any issues.

If there is no resolution to the problems between services, it is the responsibility of the Attendings on both services to discuss the matter and come to a resolution.

The Chief Resident(s) should always be notified of such conflicts so they may assist housestaff in such matters.

Scheduling and Schedule Requests

The Chief Residents are responsible for making the Resident and Intern schedules for each academic year. In making the schedules, the primary responsibility of the Chief Residents is to 1) ensure that all the minimum training requirements set forth by the ACGME and ABIM are met, and 2) ensure that all teaching services are fully staffed throughout the year and 3) ensure the safest care is being delivered to patients at all times.

At least one month prior to creating the yearly schedules, the Chief Residents will send a schedule request form to the Residents. This form will guide scheduling assignments; however, it **does not guarantee** a request will be granted.

Once the Yearly (Block) Schedule is released, all schedule changes, new requests, or switches need to be made in writing(email) to the Chief Residents at least 3 months prior to the proposed change.

Any request for schedule changes cannot negatively affect the Residents' clinic coverage or result in closure of his/her clinic.

The Chief Residents reserve the right to deny, modify, or accept the proposed changes. This policy is to preserve the integrity of #1-3 above. The official schedule is available online on the housestaff website.

Back-up Guidelines

Residents and Interns will be scheduled for Back-Up to cover unforeseen absences by other housestaff. The back-up schedule will be posted in advance so each Intern and Resident will know when they are responsible. It is the responsibility of the individual House staff member to know what days they are on back-up and to plan accordingly. **It is expected and professional that the back-up Resident has their pager on 24 hours a day during the days that he/she has been scheduled. In addition, the Back-up Resident/Intern should be within 30 minutes of the hospital and accessible by telephone at all times that they are on back up.**

Both Interns and Residents will be assigned to a half-month block during their elective blocks. During that time, they are expected to:

1. Keep their pager on **24-hours a day**...no exceptions (i.e., at the gym, running, etc).
2. Be accessible by phone.
3. Be available to come in within 30 minutes, 24-hours a day.
4. Not be out of town for any reason.
5. **Make no definitive plans** as they may be called in.
6. Drinking alcohol is not allowed during this time as residents/ interns may be called in at any time.

It is the responsibility of the individual Resident to obtain coverage for back-up in the event they have a conflict with the finalized back up schedule. There will be at least 2 PGY-1's and 2 PGY-2's or PGY-3's on back-up on any given two week period.

As with any scheduling changes, **all back-up switches must be timely and submitted in writing to the Chief Resident for approval.** The back-up schedule is available on the master schedule located on the Google Drive. It is every Resident's responsibility to know when they are on back up and abide by the terms detailed above. Failure to abide by the aforementioned responsibilities will result in further disciplinary action.

When Will Back-up Be Called In?

The back-up system is designed to cover the services designated below in the instance of an unforeseen absence by a member of the housestaff. Back-up should only be used for extreme personal illness, sudden family death, or sudden illness of an immediate family member. Back up may also be called in if the situation arises of a Resident's fatigue, stress or extended hours. It is **unprofessional and inappropriate** to use back-up for planned events, foreseen absences, fellowship interviews, birthdays, or anniversaries. The Chief Residents and the Program Administration have the right to alter and determine if a reason for back-up is appropriate.

Consequences for inappropriate utilization of the back-up service may include additional time on back up, additional night team, or additional Friday night coverage.

If a Resident feels back-up needs to be called, they will first notify the Chief Resident On-Call (413-4553). The Chief Resident on call will make the determination if the back-up request is appropriate. The Chief Resident on call will then notify the Resident on back-up to come in to cover the service. Failure by any Resident on back-up not to answer their page or be unavailable is a serious violation of professional conduct. This violation will be noted in the Resident's personnel file. In addition, the Resident will be referred to the Housestaff Evaluation Committee for further action.

Back-Up Responsibilities

Back up responsibilities are assigned during elective blocks. Back-up is not assigned during rotations on ambulatory, inpatient wards, ER, MICU, or night team.

It is each Resident's responsibility to look over their back-up schedule every month for scheduling errors. Should back-up be required for greater than a 24 hour period, the policy is as follows:

- The back-up Resident will come in and perform the duties of the absent Resident until the absent Resident is again able to perform their duties or back-up duty changes.
- For extended back up or mitigating circumstances, the Chief Residents may alter the entire program's schedule to allow for better patient care and Resident education.

What Services are covered by Back-Up?

The back-up responsibilities are crucial to the smooth functioning of the academic hospital system. All inpatient Housestaff run services will be covered by back-up in the case of an emergency. This pertains to the general medicine services at UF Health, the three sub-specialty services at UFH, the General Medicine services at the VA, the MICU at both the VA and UFH, the VA GEM unit, the Medicine Consult Service at UF Health, the AOD, the Bridge Residents at either UF Health or the VA, the CCU at UF Health and Night Team. Also, backup may be required for Friday Night coverage and the ED. Should a Resident be unable to attend their continuity clinic, the back-up Resident may be asked to cover that Resident's clinic at the discretion of the Chief Residents and the Program Director. Residents will not be asked to cover for non-housestaff associated services or for Interns/Residents absent from electives.

Order Writing

At both the VA and UF Health orders are to be written by Interns and Residents only. In cases of emergency, attending physicians and consulting services may write orders. If they are to do this we require that they contact the Intern and/or Resident taking care of the patient to inform him or her of the order.

Chemotherapy Orders Policy

UF Health-UFH Hospital: All patients on chemotherapy at the time of admission should be admitted to the Hematology/Oncology Teaching Service. Exceptions to this policy due to other mitigating medical problems may occur – but only with the permission of the Hematology/Oncology Attending Physician.

- For patients on the Hematology/Oncology Teaching Service, only the Fellow or the Attending Physician will write chemotherapy orders.
- For patients on the General Medicine Services, only the Oncology attending or fellow can write

cancer chemotherapy orders. The Oncology Consult Service must be notified within 24 hours of an admission of a chemotherapy patient on a General Medicine Service. Once consulted, the Oncology Service should continue to follow the patient throughout the hospitalization.

VA Hospital: All chemotherapy orders at the VA for either inpatients or outpatients will be written by the attending oncologist. VA Memorandum 119-8 has further details governing chemotherapeutic agents.

Resident Supervision

Residents will be supervised by attending faculty in all patient care duties. Attendings are available 24 hours each day to assist Residents/Interns with the management of patients. If a Resident or Intern has questions or concerns related to the acute care of a patient the attending should be contacted. At no time will an attending at UF Health or the GVAMC be responsible for the supervision of more than 8 learners (including Residents and students) within a team. In the outpatient setting the precepting faculty will be responsible for no more than 4 Residents during a given session.

Educational Funding

All PGY-2 AND PGY-3s will be provided access to online MKSAP software.

Policy on Regional or National Academic Conference Attendance

The Department of Medicine Residency Program encourages Residents to become active members in national academic, research, or special interest societies. In doing so, the Department promotes Residents to attend local, regional, and national conferences as presenters of their own research or as general attendees to further their education. The following general guidelines and regulations should be followed to facilitate these educational opportunities:

1. The Department will pay for each categorical Resident's yearly membership to the American College of Physicians (ACP).
2. All Residents are strongly encouraged to attend and present at the annual ACP-Florida meeting in the Fall, and the annual ACP-Florida Associates meeting in the Spring. The Department will reimburse Residents for travel and accommodations for attendance at these meetings when Residents present an accepted poster/ oral presentation only. The Residents are responsible for making sure they have appropriate coverage for required rotation; the Chief Residents can provide assistance if needed and must approve of the coverage prior to travel.
3. The Department also encourages Residents to attend and present regional and national meetings of recognized academic, research, or special interest societies. If a Resident plans to attend any regional or national meeting, 60 day notice needs to be provided to the Program Director and the Chief Residents to accommodate scheduling changes; the Resident is responsible for making sure they have appropriate coverage for required rotation; the chiefs can provide assistance if needed. Any subspecialized meetings should be sponsored by their mentor/ division of the subspeciality.
4. If a Resident is asked to present academic material at a regional or national meeting, funding for travel and accommodations should first be requested through the Resident's research mentor. If funds are not available, the Resident should submit in writing a request to the Program Director no later than 60 days prior to the conference.

Parental (Maternity/Paternity) Leave Policy

All requests for parental leave must be submitted as soon as the needed time to be off is known and must be approved by the Program Director. All such requests will be kept confidential.

Parental leave may be taken for up to six weeks, as outlined below. Provided sufficient vacation time and sick leave remain, no make-up time will be required:

- 3 weeks (15 days) of Vacation: This is the entirety of vacation allotted to an Intern/Resident in any given academic year.
- 2 weeks (10 days) of Sick Leave: Residents have 10 days of sick leave per academic year. Unused sick leave may not be carried over from one academic year to the next.
- 1 week EBM: During this week the Resident is required to attend their continuity clinic but are excused from EBM activity during this time. The EBM curriculum will be incorporated into an elective/ ambulatory month later in the year.

If additional leave time is required or if the Resident does not have adequate vacation/sick leave remaining, that time will be added to the end of the academic year in order to fulfill the requirements for completion of residency training.

For additional information, please refer to the complete policy obtained through the Residency Program Office. Questions can be directed directly to the associate program directors, faculty mentors or the Chief Residents.

Inpatient Teams at UF Health

There are inpatient teaching services at both the VA and UF Health (UFH). UFH has three General Medicine Resident/Intern teams (Blue, Orange, and Gold), one General Medicine Resident Hospitalist team (Green), and three subspecialty teaching services (GI/Liver, Oncology, and Cardiology). UFH also has MICU and CCU rotations.

General Information

Patient Care Resource Manager (PCRM) Responsibilities: There is one PCRM assigned to each team at UFH. Their major role is to facilitate discharge planning and secure funding of the patient's hospitalization.

Charts: At UFH, a history and physical should be entered by the Intern (or Resident if on the Green service) on every patient. This should be done in a timely manner and should be done prior to leaving for the day. They should be typed or dictated into the EMR. It is the Resident's responsibility to ensure that no patient is without an H&P in the chart when he or she leaves the hospital.

Progress notes should be entered daily on all patients. Third year medical students should write the progress notes on their patients. Interns must also write their own separate progress note including subjective, physical exam and assessment and plan. The Interns/Residents must read and co-sign the third year medical students progress notes daily. Feedback on deficiencies should be given. Fourth year medical students are supervised directly by the Resident. The Resident must co-sign the 4th year student's

note in addition to writing his/her own separate progress note on their sub-I's patients. On the Resident's day off the interns on service are responsible for writing notes on the 4th year medical student's patients.

Off-Service Notes/Transitions of Care

Transfer Notes: When you **transfer** a patient (e.g., from the floor to the MICU or vice versa) write a summary note of the patient's (1) hospital course to date, (2) current physical exam, and (3) overview of assessment and plan. When you **accept** a transferred patient the accept note indicates (1) you have read the transfer note, (2) documented your exam and (3) outlined the plan of care.

Off-Service Notes: At the end of a block, each patient requires an off-service note with a (1) summary of the hospital course to date, (2) current physical exam, and (3) long-term plan, including current discharge plans. These notes make signing out your service and coming onto a new service much smoother. This does not replace verbal sign-out to the next Intern/Resident.

Discharge Summaries

After the first three months of Intern year, discharge summaries are performed by the Intern if the length of stay is 4 days or less (including the day of admission and the day of discharge) on the General Medicine services. The intern is encouraged to write the discharge summary for patients whose LOS are >4 days, however the resident is ultimately responsible for ensuring that all discharge summaries are completed. Discharge summaries must be completed within 48 hours of discharge.

Students can write the discharge instructions but they need to be edited by the Intern and Resident.

The discharge process is different after a patient dies. The Resident or Intern must write a death note, complete the death packet, and write a death/discharge summary. Discharge instructions and discharge medication reconciliation are not required in these cases.

Delinquent Medical Records: You will be notified via email regarding delinquent discharge summaries from Health Information Management. The Chief Residents and Program Director will also be informed notified at this time and will send out further reminders. Once a Resident has been contacted about incomplete charts, the Resident has 48 hours to complete those notes. All chart completion in a timely manner is a professional obligation of a Resident. **All Residents are required to check EPIC weekly, and CPRS monthly.**

Notification of Primary Physician: The admitting team should always route H&P's and discharge summaries along with any other pertinent records to the patient's primary care provider. Verbal communication is also encouraged when possible.

Autopsies: Residents should attend to all autopsies on their patients. There will be occasions for case review at Morbidity and Mortality, noon conference, and morning report. It is important to ask family members of the deceased if they would like an autopsy, as it often is a good teaching tool, may shed light on the underlying diagnosis, and may provide an element of closure for the family.

UFH Transfer Center (ext. 50559 or 43540): The Transfer Center coordinates requests for transfer of patients from outside hospitals and emergency departments to our hospital. The following policy has been established to improve communication between the outside physician and the admitting team. In addition it ensures patients are admitted to the appropriate medical service and ward.

1. Referring providers place calls to the UFH transfer center for patient transfers which are then routed to the appropriate physician. For general medical patients this goes to the Hospitalist AOD. When the patient arrives, the Hospitalist AOD and Resident AOD discuss to which service the patient will be admitted.
2. For patients needing transfer to a medical sub-specialty service (MCT, MGI, Heme/Onc, MICU), the call to the transfer center will be routed to either the fellow or attending physician in that specialty on service or on call at that time. When the patient arrives the Hospitalist AOD is generally notified first who then communicates with the Resident AOD. If the accepting team has not already been notified of the patient's arrival, the Resident AOD should then inform the accepting team.
3. Once any patient is accepted by any medical service for transfer to UFH, an appropriate H-H transfer email should be sent using the DoM template which can be found at https://intranet.ahc.ufl.edu/www/Colleges/com/dom/im_hospitalists/SitePages/DOM_H_to_H_xfer.aspx.
4. At any time the accepting physician(s) may request status updates through the transfer center. In general, the transferring hospital should speak directly with the Hospitalist AOD immediately prior to transfer to provide updates on condition and arrival estimate.
5. If a fellow or attending is contacted by an outside facility or physician for transfer of a patient, they cannot directly accept the patient to a housestaff associated general medicine team. They should either contact the Hospitalist AOD to discuss transfer of the patient.
6. Per UFH policy, any patient transferred from an ICU at another facility must initially come to an ICU here at UFH. Once evaluated by the accepting team, the patient can be transferred to the appropriate ward/level of care.

Cross-Cover

Patients on housestaff-associated teams will always have a physician in-house to provide cross-coverage. Between 7 p.m. and 7 a.m., the cross-coverage is performed by a resident at UFH, and an Intern, one at UFH and one at the VAMC. If the long-call or specialty teams are still in house at 7 p.m., each Intern should stop their work to sign out with the night cross-cover physician at that time. The cross-cover physician must be given a written list of patients which includes (for each patient): name, medical record number, patient location, allergies, code status, and items that need to be checked and plans to deal with those checked out items, including what to do with abnormal results. More details about active issues and anticipated issues should be updated daily in Epic.

If a Resident orders an emergent study, it is the responsibility of the Resident to follow-up on the study and determine a plan of care. This should **NOT** be checked out to the night team. Also, consents for blood transfusions or procedures should be addressed by the primary service during the daytime and not left to the night cross-cover physician.

Bridge Resident Daytime Cross Cover

At UFH during the week (Monday – Friday 7am-7pm.) the bridge resident carries both the intern and resident cross cover pager for emergencies only. They will provide cross coverage for all the house staff service patients on the IMC and general floors in the North Tower after the teams have signed out or if the primary team is not available or cannot be reached. They will be the first line contact for urgent calls from

the 24 and 94-IMC.

At the VAMC during the week (Monday – Friday 7am-7pm), the VA MOD resident carries the cross cover pager as well as one of the dedicated code pagers. As is the case at UFH, they will provide coverage for all the house staff services outside of the MICU after the teams have signed out or if the primary team is not available or cannot be reached (refer to section on VA MOD roles and responsibilities for further details).

Night Cross Cover

Interns:

The UFH North Tower Cross Cover Intern is responsible for providing cross-coverage to the (4) general medicine teams, MCT, and MGI in the North Tower from 7pm-7am.

The UFH South Tower Cross Cover Intern is responsible for providing cross-coverage to the hematology and oncology team (Unit 8E) in the South Tower from 7pm-7am, Saturday - Thursday. On Fridays, cross cover for the hematology and oncology team will be provided by the Night AOD resident. In addition to the cross coverage, the south tower cross cover intern can assist the Night Resident AOD resident and perform up to two admission to any of the teaching teams. The note, plan and orders will be reviewed directly with the Night AOD resident. The south tower cross cover intern is to be directly supervised by the night resident AOD.

The VAMC Cross Cover Intern is responsible for providing cross coverage to the (4) general medicine teams, the GEM unit, and the palliative care unit from 7pm-7am. They are also responsible for up to 2 admissions to medical teams (1 during the first 6 months of the academic year) supervised by the night hospitalist.

Residents:

The UFH Cross Cover Resident is responsible for providing cross coverage to all IMC level patients on the general medicine and subspecialty teaching services along with all the medical patients in the CCU in the North Tower from 7pm-7am. This includes heart failure patients on unit 94 and those in the CCU but excludes all other heart failure services (MCH) patients. Additionally, they are responsible for admissions that are direct admits or hospital to hospital transfers to the North Tower medical services including the general medicine teaching services, MCT, and MGI. **In the South Tower, all medical patients including those on the Heme/Onc teaching service (on Fridays) are cross covered by the South Tower intern or resident AOD from 7pm-7am.**

Housestaff cross cover does not provide coverage for the Hospitalist services or for non-house staff inpatient medicine teams (e.g. Heart Failure or MCH, MCI, MCE, Bone Marrow Transplant, GI Procedure service, Ortho co-management, or Lung Transplant service). If you happen to be paged regarding one of these services, politely state that you are not providing coverage and that the individual who paged you should contact the primary service for cross-cover issues.

At the end of the night shift beginning around 6:45am, the night cross cover physicians should meet face to face with the day teams in designated areas to sign out overnight issues and updates. On weekdays, the cross cover pager is then passed to Bridge Resident at UFH and the VA MOD Resident at the VAMC. On weekends and holidays, the cross cover pager is passed to the late call resident that day.

On Fridays, the UFH night cross cover responsibilities will be covered by a resident/ intern from elective, ambulatory or a non-ward service. This is done to provide a day off for the scheduled night team and will be posted online with the initial schedule. As with the rest of the schedule, it is subject to change.

It is only through effective check-out procedures that quality patient care and patient safety are maintained. All housestaff at UFH must utilize the Epic patient sign out for daily updating of their sign-outs; Residents should supervise Intern and sub-I sign-outs. The check-out will be performed in a standardized fashion using the shift handoff tool in CPRS.

On Call Meals: Food and drink options are available 24 hours a day. There are also vending machines open 24 hours a day. Residents have a lounge on the 6th floor of the UFH North Tower supplied with sodas, milk, water, access to a coffee maker, crackers, and cereal 24 hours a day free of charge. Also, Gator bites (on-call meal money) are provided to all Interns/ Residents.

Call Rooms: Since ward services do not stay overnight they do not have overnight call rooms. The UFH Night Team Resident Room (9430) has beds in case there is enough downtime to sleep. The VA Cross-Cover Intern also has a room on 4 West with a bed if they would like to rest during their time on duty. Both of these rooms have computers to check labs or review records. There are lockers available in the night team room at UFH if you need to store anything. You may bring your own lock to secure your valuables but are required to remove the lock at the end of your rotation. The MICU is also provided with private call rooms with access to a bathroom and shower. All call rooms at UFH are code protected.

Security: Security is available 24 hours a day. We strongly encourage all Residents walking to and from the parking lot in the evening to request a security escort. Security can be reached at 265-0109 for UFH. At the VA you can call the operator and ask for security at extension 6060. If arriving at night you can call security ahead of time so they can escort you in.

Library: There is a housestaff library located on the 4th floor of UFH in the Internal Medicine office which is available on weekdays from 8am to 5pm. The UF Health Sciences Library is open from Monday to Thursday from 8am to midnight. On Friday the library closes at 7pm while on Saturday it closes at 5pm. On Sunday the library is open from 10am to midnight. Through the Internet many resources are available to medicine Residents. In particular, *Up To Date* is now available on all UFH and VA computers. Other Internet resources can be accessed through the Internal Medicine Residency Web Page or through the UF Medical Library. The VA library is located on the 4th floor as well, and can be accessed during normal business hours.

UFH General Medicine Teams

Call Schedule:

The General Medicine teams have a Trickle Admission System which started April 2013 at UFH and in June 2013 at the VA (example calendar posted below). Three teams will be on call on any given weekday and 2 teams on call on the weekend days. At UFH, the General Medicine teams consist of Gold, Blue, Orange, Red and Green. Four teams (Gold, Red, Orange and Blue) consist of one resident, two to three interns and medical students. The Green Medicine team consists of two Residents and no interns. The four day call schedule is as follows: Early call, Mid- Call, Late- Call, Golden. Over the weekend, there is no Mid- Call.

There is no overnight call for the inpatient teams. Overnight admissions and cross-cover are handled by the night team. All patients worked up by housestaff including “bounces”, MICU transfers, and new admissions count towards the total team cap. **MICU admissions will be limited to 2 per team per admitting day.** Housestaff do not admit patients to non-housestaff associated teams. The same rules apply to the 4 resident teaching teams at the VA.

Early Call: Admits up to 6 patients from 7am to 1pm Monday thru Sunday. Up to 2 holding notes may be admitted by the night team to the next day’s Early Call team. These holding notes count toward the Early Call team’s admission cap for that day. Notification of these holding notes should be posted in the appropriate team’s call room overnight or the Resident should be informed by timely online communication. Monday through Friday, the AOD will admit patients to the Early call team by assisting with throughput in the ED. On Early call days, when the Admitting Resident is off for that day, the AOD will work closely with the admitting team and place complete orders for the patients and communicate closely with the team interns and the bridge resident (who is covering the off resident) concerning the patients.

The Early Call team can sign out by 3pm every week day to the UFH Bridge Resident and 1pm on weekends.

Mid Call: Admits up to 5 patients from 10am to 4pm Monday through Friday. Up to 1 holding note may be admitted by the night team to the next day’s Mid Call team. These holding notes count towards the Mid Call team’s admission cap for that day. Notification of these holding notes should be posted in the appropriate team’s call room overnight or the Resident should be informed by timely online communication. Monday through Friday, the AOD will admit patients to the Mid Call team by assisting with throughput in the ED. The Mid Call team will be responsible for the complete admission. In the event the Resident is off or in clinic, the AOD and UFH Bridge Residents will assist the interns with any and all admissions.

The Mid Call team can sign out by 5pm every day to the UFH Bridge Resident.

Late Call: Admits up to 5 patients from 1pm to 7pm Monday thru Sunday. Up to 1 holding note may be admitted by the night team to the next day’s Late Call team. These holding notes count toward the Late Call team’s admission cap for that day. Notification of these holding notes should be posted in the appropriate team’s call room overnight or the Resident should be informed by timely online communication. The AOD will admit patients to the Late Call team by assisting with throughput in the ED and the team will be responsible for the complete admission. The Late Call team can sign out by 7pm every day to the Night Bridge Resident.

On weekends the Late call resident will be responsible for receiving the sign outs from the other teams

and hand off the care of those patients to the night team at 7 pm.

*****If a team does not receive a holding note, they may still admit up to 6 (Early Call) or 5 (Mid/Late Call) patients that day. *****

Golden Day: No new admissions. The team should make efforts to discharge patients in an appropriate and timely manner as well as perform necessary diagnostic tests. Teams are responsible for admission of their own “bounces” until 3 pm Monday through Friday and until 12 pm Saturday, Sunday and designated Holidays.

An example calendar is posted below:

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1 Early – Gold Mid – Blue Late – Orange Golden – Red	2 Early – Red Mid – Gold Late – Blue Golden–Orange	3 Early –Orange Mid – Red Late – Gold Golden–Blue	4 Early – Blue Mid – Orange Late – Red Golden – Gold	5 Early – Gold Mid – Blue Late – Orange Golden – Red	6 Early – Red Golden – Gold Late – Blue Golden–Orange
7 Early –Orange Golden – Red Late – Gold Golden –Blue	8 Early – Blue Mid – Orange Late – Red Golden – Gold	9 Early – Gold Mid – Blue Late – Orange Golden – Red	10 Early – Red Mid – Gold Late – Blue Golden–Orange	11 Early –Orange Mid – Red Late – Gold Golden –Blue	12 Early – Blue Mid – Orange Late – Red Golden – Gold	13 Early – Gold Golden – Blue Late – Orange Golden – Red
14 Early – Red Golden – Gold Late – Blue Golden–Orange	15 Early –Orange Mid – Red Late – Gold Golden –Blue	16 Early – Blue Mid – Orange Late – Red Golden – Gold	17 Early – Gold Mid – Blue Late – Orange Golden – Red	18 Early – Red Mid – Gold Late – Blue Golden–Orange	19 Early –Orange Mid – Red Late – Gold Golden –Blue	20 Early – Blue Golden– Orange Late – Red Golden – Gold
21 Early – Gold Golden – Blue Late – Orange Golden – Red	22 Early – Red Mid – Gold Late – Blue Golden–Orange	23 Early –Orange Mid – Red Late – Gold Golden –Blue	24 Early – Blue Mid – Orange Late – Red Golden – Gold	25 Early – Gold Mid – Blue Late – Orange Golden – Red	26 Early – Red Mid – Gold Late – Blue Golden–Orange	27 Early –Orange Golden – Red Late – Gold Golden –Blue
28 Early – Blue Golden – Orange Late – Red Golden – Gold	29 Early – Gold Mid – Blue Late – Orange Golden – Red	30 Early – Red Mid – Gold Late – Blue Golden–Orange	31 Early –Orange Mid – Red Late – Gold Golden –Blue			

Caps:

Team Cap: 20 patients

Individual Intern/Resident Caps:

Resident: 20 patients

Intern: 10 patients

Early Call: 6 patients/day (excluding \leq 72 hours bounce backs)
Mid/Late Call: 5 patients/day (excluding \leq 72 hours bounce backs)

If during a call day one of the Interns is in danger of going over 10 patients because of the uneven distribution of patients from that call day, then the Resident will admit and manage those patients that were supposed to go to the Intern but could not because he or she is capped at 10. Once the Intern falls below 10 patients, the Resident then can transfer those additional patients back to the Intern.

Absolute individual Intern/Resident caps (per RRC/ACGME):

-5 patient work-ups per Intern/24^o and 10 patient work-ups per Resident/24^o
-8 patient work-ups per Intern/48^o and 16 patient work-ups per Resident/48^o

Interns' longitudinal caps are 12 patients and Residents are 24 patients

Days Off:

Ideally interns should take Golden days off, preferably on the weekend. If absolutely necessary, interns could take other days off but CANNOT do so when the Resident or other Intern on service is off or in clinic. Residents should try to take EITHER a Golden Day or an Early Call day off. **It is okay to take a Mid or Late Call day off only if you first get approval from the attending physician on service.**

NO ONE should take the first or the last day of the rotation off without approval from the attending physician on service and/or the chief residents.

On the FIRST DAY of the rotation, the resident should sit down with all interns (including Sub-I's) involved and make a calendar of days off. If ANY early call days are planned to be off days for the resident, this should be communicated to the AOD and Bridge Resident as early as possible.

Team Room Numbers (Phone Numbers):

Orange – 6434 → (50138 or 50392)
Gold – 6534 → (46552)
Green – 7437 → (50256)
Blue – 6502 → (46478)

Green Medicine Team

As noted, the green medicine service is intended to simulate a hospitalist experience. This team is made up of two residents and one attending. Occasionally a medical student will accompany the team. During the rotation, clinics are excused however morning report, noon conference and grand round attendance is still required.

Admissions: Starting July 1, 2017 the red medicine team will replace the green medicine team within the Q4 call cycle. Instead of the call cycle described above, the green medicine team will admit every day, up to 4 patients from the hours of 7am until 4pm. If a one of the residents is off that day then the team is to take no more than 3 admissions. If needed up to 1 of these admissions can be a holding note.

Attendings: The attendings on this service will be hospitalists and will rotate for a period of one week. Bounces to the green medicine service therefore will only be dependent on the presence of the same resident and not the resident attending combination.

UFH Subspecialty Teams

There are three subspecialty teaching services at UFH – GI/Liver (MGI), Hematology/Oncology, and Medicine Cardiology Teaching (MCT). The MCT team consists of one attending, one Resident, two or three Interns and occasionally medical students. The GI/Liver team has a GI attending and a Liver attending, one resident, two or three interns, and occasionally medical students. The Oncology team has a solid tumor attending and a liquid cancer attending along with one Resident, three Interns, and occasionally medical students. Patients will often be accepted for admission to a sub-specialty team, yet there may be a delay in the patient actually arriving. Also, patients may be upgraded in status to the MICU team during their hospitalization. Under these circumstances, the specialty teams cannot “hold” the spot for that patient to eventually return to or come to that service. In the event that the team is capped and a previously accepted patient arrives (or comes out of the MICU), the team should make attempts to discharge patients to make room for the patient. If this does not happen, the patient will be admitted to a general medicine service.

All patients presented to the 3 subspecialty teams for admission should be discussed with the resident physician on service. If a dispute arises over the appropriate disposition of the patient, the decision should be made jointly by the fellow/attending on service and the Hospitalist AOD.

MGI:

Admitting Times: 7am-5pm Monday-Friday
7am-3pm Saturday, Sunday, and Holidays
Cap: 16 total patients
Holding Note Cap: 3
Continuity Clinic: Yes – decompressed
Team Room Number: 8409
Team Room Extension: 45717

The members of the team MUST be in-house every day by 7 a.m. to be available to admit patients and to assume responsibility for any holding notes from the night prior. All admissions should be supervised by the Resident on the service at the time of admission.

Admissions appropriate for MGI presenting between the hours of 5pm-7pm shall be completed by the Resident AOD if the patient arrives via the Emergency Department and by the UFH Bridge Resident if admitted directly to the wards as a H-H transfer for direct admission from home or clinic. These admissions count as holding notes for the MGI team the following day and should be communicated to the primary MGI team as such. After 7 p.m., admissions are done by the Night Team as holding notes to the respective teams.

The MGI team cap is 16. This is a combination of Liver and GI patients which is usually split as evenly as possible but is ultimately at the discretion of the attendings on service. Every patient admitted counts toward the cap (i.e. Bounces, MICU transfers, surgery transfers). The night team should be informed of the team’s census at check out at 7 p.m. so they know how many they can admit to each subspecialty team. Between 7 p.m. and 7 a.m., cross-coverage will be provided by the Night Team. The MGI team is expected to answer pages on their patients until 7pm every day.

Heme/Onc:

Admission Times: 7am-7pm Monday-Sunday
Cap: 20 total patients
Holding Note Cap: 3

Continuity Clinic: Yes – decompressed
Team Room Number: 8016
Team Room Extension: 29525

The members of the team MUST be in-house every day by 7 a.m. to be available to admit patients and to assume responsibility for any holding notes from the night prior. The Resident and three Interns take turns staying until 7 p.m. to admit patients, except on the weekends when the residents are allowed to sign out at 3 pm but must come back for any admissions until 7 p.m. All patients should be discussed with the Resident on the service at the time of admission.

Admissions appropriate for the Heme/Onc service presenting between the hours of 7pm-7am shall be completed by the resident AOD. After 7 p.m., admissions to the housestaff-associated subspecialty teams are done by the Night Team as holding notes to the respective teams.

The Oncology team cap is 20. Every patient admitted counts toward the cap (i.e. Bounces, MICU transfers, surgery transfers). The night team should be informed of the team's census at check out 7 p.m., so they know how many they can admit to each subspecialty team. Night cross coverage of Heme/Onc patients is through the South Tower intern or resident AOD.

The Heme/Onc team is expected to answer pages on their patients until 7pm every day.

MCT:

Admitting Times: 7am-5pm Monday-Friday
7am-3pm Saturday, Sunday, and Holidays
Cap: 18 total patients
Holding Note Cap: 4
Continuity Clinic: Yes – decompressed
Team Room Number: 5406
Team Room Extension: 46852

Admissions appropriate for MCT presenting between the hours of 5pm-7pm shall be completed by the Resident AOD if the patient arrives via the Emergency Department and by the UFH Bridge Resident if admitted directly to the wards as an H-H transfer for direct admission from home or clinic. These admissions count as holding notes for the MCT team the following day and should be communicated to the primary MCT team as such. After 7 p.m., admissions are done by the Night Team as holding notes to the respective teams.

CCU:

The CCU is a separate but related service to MCT. It consists of both MCT patients staffed with the MCT attending physician and MCH (heart failure) patients staffed with the MCH attending physician. The MCH patients include both those in the CCU on unit 25 and those in the 94 IMC on IV inotropes awaiting heart transplant. This service is composed of one PGY-2 resident and one PGY-3 resident. In addition, there is a Cardiology Fellow on both MCT and MCH to provide support, supervision, and general oversight.

Admitting Times: 7am-7pm
Cap: 14 (additional patients will either be managed by the Cardiology Fellow or mid-levels, preferably the non-ICU heart failure patients)
Holding Note Cap: unlimited
Days Off: Residents are to take 2 days off, during the week (Monday- Friday), over the 14 day rotation to be worked out with the CCU fellows at the beginning of the rotation, based on fellow clinic days and availability. Both residents will take off the same

day. If a day off cannot be arranged due to clinic conflicts, the cardiology chief fellow and IM chief resident should be contacted to provide support.

Continuity Clinic: No

Team Room Number:

Team Room Extension: 45265

Admissions appropriate for CCU presenting between the hours of 7pm-7pm shall be completed by the Cardiology Fellow on call. These admissions should be communicated to the primary CCU team in the morning via face to face handoff or email at minimum.

If an MCT floor or IMC patient requires transfer to the CCU from 7p-7a, the Night Team Resident will be responsible for the transfer summary, orders and stabilization of the patient. This will be performed under the direct guidance and supervision of the on call cardiology fellow.

- If a PA/fellow assumes care of the 94-IMC Heart failure service patients, they must complete an electronic sign out via EPIC and physically hand off to the CCU resident before 7pm each day.
- PGY2 residents on the CCU rotation will not be expected to respond to STEMI alerts but may attend if circumstances permit. Physically removing the resident from the CCU to go to the Emergency Department across the street is not ideal for patient safety.
- The CCU residents are encouraged but not required to attend noon conferences during the rotation.

Patients transferred out of the CCU will go to either the MCT or MCH teams. If the MCT team is capped, then the patient can be transferred to a general medicine service or by the MCT fellow and attending separately if they so choose. MCH patients transferred out of the CCU will remain on the MCH service and be seen by the MCH Fellow or one of the mid-level providers on that service.

UFH MICU

The UFH MICU team will be comprised of four Residents and four Interns. Total required critical care experience, including MICU and CCU, will not exceed 6 months during the 3 years of residency training. Up to an additional 2 months of critical care elective can be undertaken if approved by the Program Director. Residents will not be on call more often than every 4 days. There will be a daily lecture series presented by the MICU attending and fellows; each team member should make every effort to attend (exceptions would be the post call Resident and night Intern if by going they would violate work hours). There is now 24 hour attending or fellow coverage in the UFH MICU.

Interns: There will be four Interns in the MICU each month. The two teams each consist of two Interns and two Residents; the two teams will alternate call days. There will be at least 1 Intern scheduled on their teams long call days; Interns will be in house by 6am. One Intern will stay until 7pm, the other intern may leave earlier once patients are stabilized and work is completed with the resident's permission. Their duties on these days include working up new admissions to the MICU, pre-rounding, writing notes and providing cross coverage to the other team's patients. On short call, there will likely only be one Intern scheduled; they will be in house by 6am. Their duties on these days will include pre-rounding, writing notes on half the patients and signing out to the long call team once their work is complete. During short call days the Residents will also pre-round and write notes on half of the team's patients if one of the interns is off that day. Interns will spend a portion of their MICU rotation on a modified night float schedule; their shift will begin at 12am and they are to leave by 1pm. Their duties will include working up

new admissions overnight (this will include admitting patients to both MICU teams), cross covering both teams' patients, pre-rounding and writing notes on their team's patients. Interns will have a minimum 1 day off a week averaged over the rotation length.

Transportation of patients has been eliminated as a job duty of the Interns. If a patient's condition is critical then a Resident may be asked to accompany nursing staff in the transportation of this patient. This will be reserved for critical patients to ensure proper care.

Residents: There will be four Residents in the MICU each month. The two teams each consist of two Interns and two Residents; the two teams will alternate call days. They take overnight call on every 4th night. The short call Resident will arrive at 6am and remain until their work is complete and adequate sign out has been provided to the long call team. The duties of the short call Resident include pre-rounding and writing notes on half of the team's patients if an intern is off that day and ensuring adequate sign out is provided to the long call team. The on-call Resident will arrive at 8am and will rely on fellow Residents and Interns to present their patients on rounds that morning. The post call Resident must leave by noon the following day, no exceptions. Residents will have at minimum of 1 day off a week. This will occur on their golden day (*i.e. long call → post call → golden day → short call → long call*).

Because there will be no Intern coverage from 7pm-12am, the Night AOD Resident will admit patients from the ER to the MICU during these hours. They will be responsible for evaluating the patients in the ER and discussing the case with the in house pulmonary fellow or attending. If the patient is deemed appropriate for MICU admission, the AOD Resident is responsible for writing a full H&P, placing complete orders, and discussing the patient with the night Resident to ensure proper handoff once the patient is transferred to the MICU. While the patient remains in the ER, the AOD Resident is responsible for working closely with the ER to co-manage the patient and to ensure all appropriate procedures, access, and consults are obtained and that patient is stabilized for transport to the MICU. If after discussion with the MICU fellow/attending, the patient is deemed to not require MICU level care, the patient can be admitted as a holding note to the general medicine team with a short note from the MICU fellow/attending stating that the patient has been discussed with them and is stable for IMC admission.

All patients on newly placed BiPAP/CPAP will require an MICU consult; these patients admitted to the IMC must be able to be weaned off NIPPV within 8 hours and should be followed up by the MICU team. Patients requiring 100% NRB (unless palliative care patient) require either MICU consult or must be weaned to 50% venti-mask before eligible for IMC admission.

UFH IMC

IMC patients will be cared for by the general medicine and subspecialty teams. This is a step-up in care and will be located on unit 94 or 24 at UFH. Supervision and assistance to the general medicine and subspecialty teams will be provided by the UFH Bridge Resident. The Bridge Resident will be available from 7 a.m. to 7 p.m. while overnight coverage from 7 p.m. to 7 a.m. will be covered by the UFH Night Team cross cover Resident. (*PLEASE SEE BRIDGE RESIDENT ROLES/ RESPONSIBILITIES BELOW*).

UFH Night Team

The Night Team will work from 7pm – 7am Saturday through Thursday, with Friday night off. The team consists of two Residents and one Intern. One Resident is the Admitting Resident (usually PGY-2) and the other is the IMC (including Heart Failure Service) & CCU Cross-Cover Resident (PGY-3). The Intern provides cross-coverage under the supervision of the IMC Cross-Cover Resident. The Night Team is supervised indirectly by the Chief Residents and the Program Director. The team will perform admissions to housestaff-associated subspecialty teams (i.e., GI/Liver, Onc, and MCT), “bounces” to General Medicine teams and admissions to General Medicine teams as “holding notes”. The team also provides cross-coverage for all housestaff-associated services (Subspecialty and General Medicine teams). The cross cover Resident may assist the MICU team during the night in the North Tower.

The night team will have Friday night off. Friday night will be covered by 2 Residents and an intern. Days off may not be changed without prior approval of the Chief Residents **in writing**. A Resident will not be scheduled for more than 1.5 months of Night Team in a given year of training, with no more than 4 months over the course of the 36 months of training.

The members of the Night Team will attend Night Team intake report on the 2nd Friday morning of their rotation, held from 8:00-8:45 am in the Medicine Library. The Night Team Intern from the VAMC is expected to come to Night Team didactic session at UFH. It is expected that all issues or problems with patients or colleagues overnight are documented with names, medical record numbers and times of incidents so that it may be accurately reported to the Chief Residents. This will facilitate the necessary action to be taken to resolve the issue.

Night Team Admitting Resident (413-4587)/Night AOD:

Admission Cap: 8 (this includes patients accepted to the MICU, urgent Medicine consults in the South Tower, and patients admitted to any other medicine/subspecialty teaching service).

The admission Resident will sign out with the resident AOD at 7 a.m. and 7 p.m. for pager handoff and to review pending admissions and transfers. From 7pm to 7am the Hospitalists AOD (pager 413-1731) will work closely with the Night Resident AOD to triage all admissions to medicine services and to determine which service will admit the patient. This applies to all patients including those being admitted through the ED, H-H transfers, and late clinic admissions. It is important that the Resident and Hospitalist work together to determine which patients are appropriate for teaching services. If this is not occurring on a regular basis, the chief residents should be notified immediately.

Because there will be no Intern coverage from 7pm-12am, the Night AOD Resident will admit patients from the ER to the MICU during these hours. They will be responsible for evaluating the patients in the ER and discussing the case with the in house pulmonary fellow or attending. If the patient is deemed appropriate for MICU admission, the AOD Resident is responsible for writing a full H&P, placing complete orders, and discussing the patient with the night Resident to ensure proper handoff once the patient is transferred to the MICU. While the MICU patient remains in the ER, the AOD Resident is responsible for working closely with the ER to co-manage the patient and to ensure all appropriate procedures, access and consults are obtained and that patient is stabilized for transport to the MICU. If after discussion with the MICU fellow/attending, the patient is deemed to not require MICU level care, the patient can be admitted as a holding note to the general medicine team with a short note from the MICU fellow/attending stating that the patient has been discussed with them and is stable for IMC admission.

MICU admissions are first priority for the night Resident AOD from 7pm to 12am. If there are more than

3 MICU patients to be admitted in this period, the Night AOD resident should discuss with the MICU fellow/ attending about the need to call in back-up (either back-up resident, or MICU fellow may choose to help). As a result, general medicine admissions will be done by the hospitalist service between 7pm and 12am if the Night Team Resident is otherwise occupied.

Subspecialty admissions: The Night Team Admitting Resident (Night AOD) admits patients being admitted to GI/Liver (MGI), Cardiology (MCT) and Hem/Onc up to three holding notes for Heme/Onc and GI/Liver and four for MCT (one admitted between 5-7 pm, and 3 after 7 pm)For CCU patients please see the MCT/Cardiology section above.

General Medicine admissions: The Night AOD may admit up to 2 holding notes to the Early Call team and up to 1 each to the Mid and Late Call teams. **The exception is if a bounce needs to be admitted to a housestaff team. This will count toward the cap of 8 admissions for the Night AOD (see Bounce Policy). Any patient that was discharged from the Hospitalist service within the last 72 hours will be a bounce to the Hospitalists if the attending is the same.**

Night South Tower Cross Cover Intern (413-4587):

One PGY-1 resident provides cross-cover services for all the patients on housestaff-associated medicine services in the south tower. This includes Hem/Onc. Sign out will be received from the Hem/Onc resident at 1830 in the 8 East Team Room from 1830 to 1900. The intern is responsible for following up with studies performed at night and assisting with patient care issues throughout the night. If there is a change in patient condition, management, or the plan of care overnight, the intern cross-cover must document this with a brief SOAP note, that is co-signed by the primary team's attending. The intern has resident support by the night AOD resident.

The Heme-Onc service may sign out their patients at 5pm on weekdays and 3pm on weekends but must be available and return to do any new admissions before 7pm. If not in-house the resident must verbally discuss all patients in sign-out to the Night South Tower Cross Cover Intern at 1830.

Admissions: The night south tower cross cover intern will perform up to 2 admissions to the medical teaching services directly from the ED that arrive after 7PM. Regardless of the number of admissions earlier in the night, the Night South Tower Cross Cover will NOT admit more than 2 patients after 4AM and will NOT admit any new patients after 6AM.

Admissions done by the Night South Tower Cross Cover Intern will be done with direct supervision of the Night AOD Resident. Each admission will be signed out as a holding note for the day time teaching services.

Night 94IMC and Admission Cross-Cover Resident (413-4496):

Cross-cover: One PGY-3 resident provides cross-cover services for all the house-staff associated services on 94-IMC. Sign out will be received by the Day Bridge at 6:30 PM and by the primary team resident through verbal communication from 6:30-7:00PM. Occasionally, there may be a Medicine Consult Service (MCS) patient in the North tower that the ABO resident may call to ask the Bridge Resident to assist with issues in the North Tower.

Admissions: The night Bridge Resident will perform all Hospital to Hospital (H-H) transfers and direct admissions to the medical teaching services on the north tower that arrive after 7PM (up to 4 admissions).

Urgent Medicine Consults: Any Medicine consults that are urgent and must be seen before 7AM will be seen by the Night AOD resident after 7PM in the South tower and the Night Bridge

resident in the North tower. Any new consult seen from 7PM-7AM should be staffed by the Hospitalist AOD and then signed out in the morning to the Medical Consult Service (MCS) resident. In-house transfers to any of the inpatient teaching services will NOT be accepted after 5pm.

The total admission cap for the Night Bridge Resident is 4 per night.

The back-up for the 94IMC resident is the IMC hospitalist on-call.

Night 24IMC and CCU (Cross Cover) Resident:

Cross-cover: One PGY-3 resident provides cross-cover services for all the house-staff associated services on 24-IMC, 54-IMC (MCT) and 25CCU/MICU. A PGY-2 will only serve in this role if they have already completed their CCU rotation. Sign out will be received by the Day Bridge at 6:30PM and by the primary team resident through verbal handoff from 6:30 to 7:00PM. The Day CCU Resident must formally (in person, bedside rounds preferred) sign out all patients directly to the Night CCU Resident.

Admissions: The night Bridge Resident will perform all CCU admissions after 7PM (up to 4 admissions) with direct assistance from the cardiology fellow.

The total admission cap for the Night CCU Resident to the CCU is 4 per night.

CCU: The Bridge resident will contact the on-call cardiology fellow for any patients who they suspect need to be transferred to the CCU to help with stabilization of the patient. The resident is responsible for transfer orders and notes after transfer to the CCU. Direct back-up for the CCU resident is the cardiology fellow on-call as well as the MICU attending/fellow on-call.

Night Cross-Cover Intern (413-4599):

Admission Cap: no admissions

The Cross-Cover Intern provides cross-coverage of all housestaff-associated medicine teams, including Subspecialty teaching services but excluding Heme/Onc, MICU, IMC, and CCU. The Intern is supervised and assisted by the Cross Cover Resident. They are expected to return calls in a timely manner, and notify the nursing staff caring for a patient if there will be a delay in making it to the bedside if they are dealing with a more critical patient. **If they see a patient or make any significant observations or changes to treatment**, they should write a brief note in the chart. Verbal orders should be reserved for emergency situations only, and must be signed within 48 hours.

If a patient goes to the IMC, MICU, CCU, has a therapeutic misadventure, or dies, the Interns should call the attending responsible for the patient regardless of time of day unless the team has specifically told you that you do not need to call. The Cross Cover Intern's direct supervisor for problems or help with patients is the Cross Cover Night Team Resident. If this individual is unavailable or does not answer, page the Night AOD Resident (413-4587). If a patient is in need of immediate attention because of instability, or if the patient needs to be transferred to the MICU, please contact the MICU team directly at 219-7970. When the shift is complete at 7am, the Intern will return the check-out sheets to the appropriate teams, notify them of any overnight problems with their patients, make sure that their verbal and telephone orders are signed, make sure that all patients that need a note have one in the chart, and give the cross-cover pager to the Bridge Resident on weekdays and the Late Call Resident on weekends.

UFH Bridge Resident

Schedule: Monday through Friday 7:00 a.m. – 7:00 p.m.

Saturday/Sunday/ UF or Public Holiday: Bridge will be AOD from 7am-7pm on one of the weekend days and the other is to be their day off. This is to be worked out amongst the two Residents (Bridge and AOD). If the rotation has unequal weekend days, preference will be given to the Resident who is starting or finishing an ICU or ward rotation with only one day off per week. The Resident's Continuity Clinic will be closed during the Bridge Rotation.

UFH Bridge Resident Pager: 413-4496 (same as the Night Cross Cover Resident) or 413-4599 (as the Night cross cover Intern)

General duties and responsibilities:

The general duties of the UFH Bridge Resident will be to provide assistance with patient care to all Department of Medicine housestaff-associated inpatient services in the North tower. This includes general medicine, MGI, and MCT. Involvement may include any level of patient acuity, and may include (but is not limited to) assistance with admissions, procedures, transfers, or immediate response to acute changes in clinical status.

The UFH Bridge Resident will provide immediate availability and response to clinical questions or issues involving IMC-level patients whose care is directed by the housestaff services listed above. He/she will assist in procurement of patient beds for those requiring IMC level of care and conduct active real-time re-assessment of all IMC-level patients on housestaff-associated services. He/she will be, during his/her duty hours, the physician with whom all housestaff services will perform sign-out on IMC-level patients, and will be responsible for signing out these patients to the corresponding Night Cross Cover Resident at 7:00 p.m.

The Nurse Manager will provide a list of teaching medicine patients that do not meet criteria for admission to IMC. If downgrade is expected or needed, the Bridge Resident is responsible for notifying the team and the team's attending regarding transfer of patients out of the IMC, including placing orders, if the teams agree with the downgrade. The Bridge resident is also expected to join rounds with the teaching services in the morning when in the IMC as part of GatorRounds.

The Bridge resident is expected to attend all teaching conferences including morning report, noon conference, and Grand Rounds. Their absence will be excused if they are preoccupied with patient care activities so long as they notify the chief residents.

The Bridge Resident is to receive sign out on any acute issues on IMC patients from the night cross cover Residents and to assist the primary team in following up on any urgent issues.

IMC Patient Care:

- A) Cross Cover/Sign-out on ALL Patients during weekdays
- The hand-off of both floor and IMC patients (and both pagers) should take place:
 - At 7 a.m. & 7 p.m., between the Night Cross Cover Resident and Intern & the UFH Bridge Resident
 - The Night Cross Cover Resident is responsible for updating the list with any patients admitted to the IMC overnight

B) The Primary teams are responsible for updating their lists and checking out to the UFH Bridge Resident between the hours of 3p.m.- 7p.m during weekdays and 12p.m. – 7p.m. during weekends .

C) In the morning, the Night Cross Cover Resident. IMC patients should be signed out to the primary team.

D) All patients warranting IMC admission should be admitted using the “Medicine IMC Adult Admission Orders IP UF” order set.

Primary Contact for IMC Patients:

The Bridge Resident will be the first point of contact for IMC patients regarding **urgent issues from nursing**. It is the responsibility of the Bridge Resident to convey both critical and non-emergent information from the nurses to the primary team. If urgent issues arise, the Bridge Resident must immediately address them while actively involving the primary service in the management of the patient. The day-to-day management of the IMC patients, including the determination of whether a given patient needs to be downgraded or upgraded in care, is still the responsibility of the primary team. The IMC Bridge Resident is primarily there to respond to urgent and emergent patient care issues.

Attending Coverage for UFH Bridge Residents: The Attending of record for the medicine team that needs assistance (during the day) and the IMC Hospitalist Attending (at night). If a patient is becoming unstable, the next call should go through the MICU fellow or attending. If these efforts are unsuccessful, the Chief Resident on call should be contacted to assist with the situation.

UFH Admitting Officer of the Day (AOD)

Schedule

Rotation is for two weeks.

Monday through Friday 7:00 AM – 7:00 PM (excluding Holidays)

Days off- 1 weekend day; split with the Bridge resident who will cover AOD when off (See above).

AOD Pager: 413-4587

I. General Duties and Responsibilities

The AOD is either a PGY-2 or 3 resident. In the morning, the AOD resident serves as a triage resident and primary point of contact in the ED for the admitting teams while they are rounding. The UFH Resident AOD should see the patient, perform chart review, decide to which teaching service the patient should go and write initial orders to get the patient admitted and initially worked up and treated. The AOD resident will **NOT** function as an ED resident and is NOT permitted to do admissions for the MHS hospitalist service while on duty.

The AOD will keep a list of all patients admitted to the teaching services. In the morning, the AOD resident should get sign out from the night AOD resident and see if there are any sick patients still in the ED that need attention.. During the day, all attempts to fill the services in order of call schedule should be made (e.g. early then middle then late).

II. Medicine Consult Service Responsibilities

At 5pm the Medicine Consult Resident may sign out his or her patients located in the South Tower to the Resident AOD. The Medicine Consult Resident should continue to answer pages on these patients until 7pm, however the Resident AOD may be asked to provide emergent evaluation and or treatment to these patients when necessary. The Medicine Consult Resident should discuss this with the Resident AOD in a timely manner. In addition, any urgent/emergent consult to the Medicine Consult Service on a patient located in the South Tower after 5pm should be seen by the Resident AOD. He or she should staff these consults with the Hospitalist AOD and ensure sign-out of these patients to the regular Medicine Consult Resident the next day.

III. Weekends and holidays

On weekends and on official public holidays, the Resident AOD will take sign out from the Medicine Consult Resident after 2pm. They will hold the MCS pager, 413-7243, cross-cover patients on the Medicine Consult Service (geriatric hip fracture patients) that have been signed out to them. Any urgent consults after 5pm will be performed by the AOD/night AOD. Patients on the ortho-co-management service will be cross covered by the MHS cross-cover attending. Any requests to transfer a patient from another service to a medicine service after 5pm should generally NOT be accepted.

IV. Attending Coverage

The hospitalist AOD attending should be available to assist the AOD resident with patient care decisions. Ultimately, the UFH Chief Medical Resident (from 7am- 6pm) or the Chief on call (from 6pm-7am) and the Program Director will have the final say regarding clinical decisions and/or activities of the AOD resident if there is a question.

From 7am- 7pm, weekday (Mon-Fri) attending coverage for the Medicine Consult Service will be the Medicine Consult attending; weekend (Sa-Su) attending coverage will be the Green Medicine attending. From 7pm -7am, attending coverage will be the Hospitalist AOD attending (See MCS Roles and Responsibilities for more details).

MHS AOD Attending: 413-1731

MHS Green Medicine Attending: see individual pager list

IV. Other Resident Responsibilities

The AOD resident is not required to attend their continuity clinic while on this rotation. The AOD resident is exempt from morning report but is required to attend daily noon conference and Thursday Grand Rounds.

V. Physical Location

The AOD resident should be physically stationed next to the Hospitalist AOD attending at the medicine work station in the ED while on duty.

Inpatient VA Ward Teams

Conferences: The VA Morning Report will be held on Mondays and Fridays at 8 a.m. Attendings and medical students are also encouraged to attend.

Each month there will be a Morning Report calendar that will be posted on the Google Drive. The calendar will include date assignments to teams responsible for case discussion, as well as additional Morning Report topics that will be conducted as combined sessions in the Medicine Library at UFH. Please refer to the monthly Morning Report calendar for this schedule.

VA Library Services: Residents and fellows are encouraged to use the Medical Library on the 4th floor of the E-Wing, room 4E-420. Hours are Monday-Friday, 8am-4:30pm. Call extension #6312 (the VA library) to request a library card that enables 24-hour a day access. All VA computers also have access to *Up To Date*.

Inpatient Consults: In addition to placing a call to the consulting service, a consult request should be placed in CPRS.

Discharge Medications: Discharge medications should be reviewed and any new medications should be entered into CPRS the day before a patient's anticipated discharge. For anticipated weekend discharges, discharge medications should be ordered on Friday. A separate "Medication Reconciliation" note must be generated and reviewed at the time of discharge. This will be completed by pharmacy during the week, however it is the responsibility of the Intern and/or Resident on Saturday and Sunday. There is a pharmacist available on weekends to facilitate discharge medication review. Speak with your team pharmacist or Case Manager if you have questions.

On Call Meals: The VAMC provides long call Interns and Residents with dinner and breakfast as well as lunch on weekends. Housestaff must show identification when picking up meals. Vending machines are also available 24 hours a day in the basement.

Security: Security personnel are present on the VA campus 24-hours a day, 7 days a week. Security escorts are available in non-code situations (i.e., an uncontrolled patient), when it is dark/after hours, or at other times as indicated. Housestaff may request a security escort to the GEM unit and Nursing Home as these buildings are off-site from the main hospital campus. Housestaff are also strongly encouraged to request a security escort to UFH Hospital and to the parking lots from the VAMC, especially after hours.

Contact numbers:

VA police 4091
MAA 6724 or 6825
Operator (for security) 6060

Call Rooms: The MICU Resident at the VA has a private call room in the rear of the MICU. This allows the Resident to be in close proximity of his or her patients in case of emergency. This call room also has a working bathroom with shower facilities. The on call intern has a private call room located on 4-West with sink, refrigerator, computer, phone and bed.

Call Schedule

Admissions take place using the four day trickle system rotation. The four day call schedule is as follows: Early call, Mid- Call, Late- Call, Golden. Over the weekend, there is no Mid- Call.

There is no overnight call for the inpatient teams; overnight admissions and cross-cover are handled by the night team. All patients worked-up by housestaff including "bounces", MICU transfers and new admissions count towards the total team cap. Housestaff do not admit patients to non-housestaff associated teams.

Early Call: Admits up to 5 patients from 7am to 1pm Monday thru Sunday. Up to 1 holding note may be admitted by the night team to the next days Early call team. These holding notes count towards the Early call team's admission cap for that day. Notification of these holding notes should take place in person during morning sign-out and via CPRS. Monday through Friday, the Resident MOD will evaluate and place admission orders for patients admitted to Early call team to improve throughput in the ED and

safety for patients arriving on the floors. On Early call days, when the Resident is off for that day, the Resident MOD will work closely with the admitting team and place complete orders for the patients and function as a bridge resident (who is covering the off resident) concerning the patients.

The Early Call team can sign out by 3pm every week day to the Resident MOD and to the late call team at noon on weekends.

Mid Call: Admits up to 5 patients from 10am to 4pm Monday through Friday. If the Early call team fills prior to 10am, the Mid Call team may take admissions prior to 10am. Up to 1 holding note may be admitted by the night team to the next days mid call team. These holding notes count towards the mid call team's admission cap for that day. Notification of these holding notes should take place in person during morning sign-out and via CPRS. Monday through Friday, the Resident MOD will evaluate and place admission orders for patients admitted to Mid call team prior to noon. After noon conference, the Hospitalist MOD will inform the Team of their admissions. The Team will be responsible for the complete admission.

The Mid Call team can sign out at 5pm on weekdays to the Resident MOD.

Late Call: Admits up to 5 patients from 1pm to 7pm Monday thru Sunday. If the Early and Mid-Call teams fill prior to 1pm, the Late Call team may take admissions prior to 1pm. Up to 1 holding note may be admitted by the night team to the next days Late Call team. These holding notes count towards the Late Call team's admission cap for that day. Notification of these holding notes should take place in person during morning sign-out and via CPRS. The Hospitalist MOD will inform the Team of their admissions and the team will be responsible for the complete admission. The Late Call team can sign out by 7pm every day to the Night Intern.

On weekends the Late call resident will be responsible for receiving the sign outs from the other teams and hand off their care to the night team at 7 pm.

Golden Day: No new admissions. The team should make efforts to discharge patients in an appropriate and timely manner as well as perform necessary diagnostic tests. Teams are responsible for admission of their own "bounces" until 3 pm Monday through Friday and until 12 pm Saturday, Sunday and designated Holidays.

Overnight admissions: From 7 pm to 6:30 am daily, the Overnight Admitting Physician will perform medicine admissions. The Early call Resident will be available for the first admission notification at 7 am.

VA Bounce Policy: "Bounce-backs" are patients once cared for by a teaching team that have been discharged and are readmitted. A bounce will be admitted to the **same Intern/Resident combination** (regardless of the attending). Teams are responsible for admission of their own "bounces" until 3pm weekdays and 12am on weekends and holidays. A "bounce" admitted after these hours will be managed by the late-call team (in this situation, the patient will count as an admission for the Late Call team) or the Hospitalist and will be a holding note for the appropriate team the next morning.

The "bounce" will count as an admission for the receiving team if the patient has been discharged for more than 72 hours. If the patient was discharged less than 72 hours prior to readmission, they will not count as an admission but will count towards the team cap.

Off-Service Notes/Transitions of Care

Transfer Notes: When you **transfer** a patient (e.g., from the floor to the MICU or vice versa) write a

summary note of the patient's (1) hospital course to date, (2) current physical exam, and (3) overview of assessment and plan. When you **accept** a transferred patient the accept note indicates (1) you have read the transfer note, (2) documented your exam and (3) outlined the plan of care.

Off-Service Notes: At the end of a block, each patient requires an off-service note with a (1) summary of the hospital course to date, (2) current physical exam, and (3) long-term plan, including current discharge plans. These notes make signing out your service and coming onto a new service much smoother. ***This does not replace verbal sign-out to the next Intern/Resident.***

MICU

The VA MICU is staffed with 4 upper level Residents. These Residents monitor a total of 12 patients in the MICU/CCU. Residents take turns taking overnight call every 4th night and will also have a day off (post-post-call day) every 4th day on service. The MICU/CCU has a call room that has a bathroom and shower facility. The long-call Resident is responsible for all new admissions to the unit, while the short-call Resident is responsible for assisting with daily notes, procedures, or emergencies. The post-call Resident leaves after rounds to ensure that the team members stay under the 80-hour work week requirement and under the 24+4 consecutive hour limit. The short call resident is required to arrive by 6:00am in order to help with pre-rounding, notes, and new MICU evaluations. All patients evaluated by the MICU resident, regardless of time, must be discussed with the on call fellow or attending, who should participate in the decision to admit and management.

GEM/Palliative Care Unit

The GEM unit is a long-term care facility that provides exposure to geriatrics, rehabilitative medicine, physical therapy, occupational therapy, and homecare. The Palliative Care unit provides exposure to end-of-life care issues. One Resident and one Intern are assigned to this rotation per month. They take turns covering the weekends, thus allowing each Resident an average of 1 day off per week or 4 in a month time period. On Saturdays, the covering Resident/Intern sees all of the patients on the team. It is the responsibility of this Resident/Intern to call the Attending and give verbal sign-out to that Attending. When all active issues have been addressed, the Resident provides a sign-out sheet to the long-call team. On Sundays, the Resident contacts the GEM unit to address acute issues. If necessary, the Resident may have to come in. If there is nothing to address, the Resident then calls the on-call team for verbal sign-out.

VA Cross-Cover/Night Team

Day Cross-Cover: Resident MOD will perform cross cover duties and hold the code pager from 7 am to 7 pm after receiving proper sign out from each individual medicine housestaff service. On weekends, the long call resident will hold the code pager and take sign-out prior to 7pm.

Night Cross-Cover: At 7 pm, the Resident MOD will verbally check-out to the night cross-cover Intern, who will perform cross-coverage for all patients cared for by housestaff services, including those in the GEM/Palliative Care unit. The Intern will cover from 7 pm – 7 am daily, except for Fridays which will serve as the Intern's day off for the week. On Fridays, one Intern or Resident on an elective or ambulatory rotation will provide cross-coverage from 7 pm until 7 am.

The housestaff associated teams will **not** provide cross-coverage for patients followed by the non-housestaff associated teams, patients on the 23 hour observation service, short-stay service or patients followed solely by an attending physician or a physician extender.

It is the responsibility of the cross cover Intern to return pages in a timely fashion and document changes in clinical status or care of a patient in CPRS. **The patient's primary team should be co-signed to the documentation and verbal check out should occur as well.**

Night Team Supervision: The Overnight Admitting Physician (attending) Night Hospitalist supervises and assists the night cross-cover Intern from 7 pm to 7am. If a physician is needed to evaluate any unstable medicine patient on a non-housestaff associated team, the Intern or Resident on call may assess the patient and provide assistance in establishing appropriate immediate medical care for the patient.

VA Resident MOD

A PGY2 or PGY3 will be assigned to this function Monday-Friday from 7am-7pm and will have a number of duties. At 7am, they will assume responsibility for the cross-cover and code pagers from the Night Intern. From 7am-Noon, they will assist the admitting teams by evaluating patients being admitted to their services and placing preliminary orders. From noon until 7pm, they will function as the Bridge Resident. This entails providing coverage to residents on their day off and while they are in clinic including assisting with patient care-related issues, including procedures, admissions, and calling consultations. If the MICU requires additional assistance, they may also provide support to the MICU resident. The Resident MOD will not be assigned to continuity clinic. The Resident MOD can do medicine consults which will be staffed and supervised by the Hospitalist MOD. The Hospitalist MOD will assign consults to the Resident at their discretion.

Medicine Consults at the VA: The Hospitalist MOD will be the contact person for medicine consults from 8 am until 5 pm on weekdays. Appropriate medicine consults may be distributed, via the Hospitalist MOD, to the Resident MOD if deemed a suitable learning case. Any patient seen by a housestaff team in a consultative role must have that patient staffed by the Hospitalist MOD. The Resident MOD must see the patient until services are no longer indicated, and provide written notice stating that the team is signing off the case.

If team or admission caps are met, patients requiring a medicine consult will be seen by the hospitalist team. The night hospitalist will cover all medicine consults between 8 p.m. and 8a.m. Those patients seen by the night hospitalist will be followed by one of the hospitalist teams if ongoing consultative care is needed.

VA Endocrine Resident

A resident will be assigned to VA endocrine duties designed to improve residents' understanding of inpatient and outpatient management of endocrine disorders. They will participate in both inpatient consults and outpatient clinics Monday-Friday with weekends off. They will be expected to attend their regular continuity clinic one half day per week as well as all morning report and noon conferences. They will also be responsible for reading materials posted on the Google Drive prior to starting the rotation. A sample schedule is as follows:

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Consults 8-10 am Attending rounds 10-11:45 am	DM clinic 8-12am	Consults 8-10 am Attending rounds 10-11:45 am	Consults 8-10 am Attending rounds 10-11:45 am	General Endocrine clinic 8-12am
PM	DM Clinic 12:30-5	Consults 1-4 pm Attending rounds 4-5 pm	Consults 1-3 pm Case Conference 3-4 pm Endocrine Grand Rounds 4-5 pm	Thyroid biopsy clinic	Consults 1-4pm Attending rounds 4-5 pm

Optional clinics:

Tuesday: General Endocrine clinic 2-4 pm

Friday: Thyroid biopsy clinic 2-4 pm

Continuity Clinic

General Information: The continuity clinic experience is one of the most important and meaningful of residency training. Each categorical Intern will have a one half day per week clinic at the start of their residency that will continue throughout the three years of the training program. During Ambulatory and Elective months, PGY-2 and PGY-3 residents will have an AM and PM continuity scheduled as determined by their clinic site. The Intern will be assigned to one of three primary clinic sites: VA Internal Medicine Clinic, UFH Medical Plaza Internal Medicine Clinic or Internal Medicine at Tower Hill Clinic. The Residents will remain at the same clinic site providing continuity of care for their panel of patients over the course of the three year residency. Residents are required by the RRC to be in clinic for 140 weeks of Internal medicine training.

Clinic Responsibilities: The Residents will be the primary care provider for the patients in their continuity clinic, working in conjunction with the attending faculty in clinic. As such, it will be the Resident's responsibility to follow up on all tests ordered and consults requested. PGY-1 Residents will be scheduled 3-5 patients per half day clinic. PGY-2 Residents will be scheduled 4-6 patients per half day clinic. PGY-3 Residents will be scheduled up to 7 patients per half day clinic. PGY-2 and PGY-3 residents will have decompressed clinics on ward months (UFH/VA Teaching teams, MCT, HEME/ONC, MGI, Medicine Consults.) No overbookings are allowed without prior authorization of the Resident or Attending. Urgent Care clinics will also be scheduled at each site which will be staffed by Residents on Ambulatory Rotation. This Resident can be scheduled up to 5 urgent visits per afternoon.

General Rules of Clinic: Clinic attendance is **mandatory**. Any change in clinic schedule must be approved by the Ambulatory Chief Resident a **minimum of six weeks** ahead of time. Any request for schedule changes cannot negatively affect the Residents' clinic coverage or result in closure of his/her clinic. The Ambulatory Chief Resident reserves the right to deny, modify, or accept the proposed changes.

1. Professional Dress is required in clinic. Scrubs are not considered professional attire.
2. No Resident should be out of clinic for more than six weeks at a time (including Vacation block, EBM, Night Float, MICU, UFH-Green Team, VA-MOD, AOD/Bridge).
3. On clinic days, Interns should give their pagers to their Residents. Residents are expected to care for the Interns' patients while the Intern is away at clinic.
4. Documentation of clinic visits will be done promptly. Notes should be completed within 24 hours of the patient's appointment.
5. Residents must check their EPIC inbox or CPRS notifications on a weekly basis. They are expected to return phone calls or address other issues pertaining to the continuity of their patients. If the Resident is going to be unable to check in with the clinic for more than one week (for example, away on service or on vacation), the Resident must notify their preceptor and have the preceptor follow all outstanding labs and test results. Medical Plaza Residents will have a designated "clinic buddy" Resident who will cover their EPIC in-basket while they are away.
6. When a patient seen in Continuity Clinic is admitted to the VA or UF Health it is the responsibility of the admitting Intern/Resident to notify the inpatient team taking care of the patient. Upon discharge the intern/resident is expected to review all pertinent hospital records (H&P, D/C summary, labs/imaging) which occurred during hospitalization.

AM Clinics: During elective and ambulatory rotations, residents will have an additional morning clinic during the week. It will be on the same day as their afternoon continuity clinic when possible.

Decompressed Clinics: When on inpatient services, senior residents' clinics will be decompressed and there will be no patients scheduled after 3pm (3.30pm at Tower Hill).

Time away from Clinic: The Residents are expected to be in clinic at the assigned time every week. Clinic continues throughout all rotations with the exception of the Medical Intensive Care Unit (UFH and VA), CCU, UFH Green Team, Night Team, UFH Bridge Resident, AOD, and Vacation. Clinics are closed on the first day of the Night Team rotation and the day after the completion of the Night Team rotation. Clinic will also be closed post-call should the Resident be on call on their final day of an ICU rotation and their clinic day falls on a post-call day. Clinics will be closed as a part of the holiday schedule. No Resident may be out of their continuity clinic for more than 6 consecutive weeks.

Clinic schedule changes: In certain circumstances, clinics may be changed or rescheduled. The rules regarding clinic schedule changes are as follows:

1. **Requests for clinic changes must be submitted with at least 3 months notice to the Ambulatory Chief Resident and/or the Program Director.** Requests for cancellations and changes in the clinic schedule must be approved by the Ambulatory Chief Resident and the Program Director.

2. If there is an emergent change (less than 45 days notice), such as illness or personal emergency, those patients will need to be seen by another Resident (either back-up or another willing Resident) unless the attending of that clinic specifically approves another plan.

Narcotic Policy at the UFH Internal Medicine Clinic: Resident clinics can be particularly prone to patients with drug-seeking behavior and chronic narcotic dependence. In order to minimize this problem and protect the Residents, the UFH Internal Medicine Clinic has developed a strict narcotic policy which Residents can specifically ask their clinic attending for further details and guidance.

1. New patients or urgent care patients will not be prescribed controlled substances (except for rare occasions at the clinic attending's discretion) and will be informed of the strict narcotic policy in

the clinic.

2. Any patient who will be taking a controlled substance for more than 1 month must have a signed narcotic contract.
3. Any patient request for adjustments or early refills of controlled substances must be done at a scheduled clinic visit with his/her primary care Resident and attending, not another covering clinic Resident or urgent care Resident.
4. Patients receiving schedule II controlled substances must come to clinic each month to pick up their narcotic prescriptions.
5. No refills of scheduled II controlled substances are permitted on one prescription.
6. Narcotic prescriptions will not be mailed to patients or called into the pharmacy.
7. A reason for each controlled substance must be clearly and extensively documented in the patient chart.

Patients who violate the narcotics contract may be discharged from clinic with the approval of the attending physician.

Ambulatory Block

The ambulatory block is a one-month outpatient rotation which is a requirement for all categorical Residents. The purpose of this block is to educate the Residents on issues pertaining to outpatient medicine as well as provide training in the ambulatory aspects of non-medicine subspecialties. During the Ambulatory Block, Residents will rotate through a combination of the following clinics:

1. Urgent Care (VA, Med Plaza, Tower Hill)
2. Neurology (Med Plaza) or Movement Disorder Clinic (Ortho Bldg on 34th St)
3. Medicine Sub-specialty Clinics (Cardiology, Gastroenterology, Nephrology)
4. Diabetes Resident Clinic (Med Plaza)
5. VA Women's Clinic (Dr. Cheema)
6. Gynecology Clinic (Med Plaza)
7. ENT Clinic (Dr. Harwick located off-site)
8. Sports Medicine Clinic (Ortho Bldg. on 34th St)
9. Equal Access Clinic (EAC)

During the ambulatory rotation, there will be a Patient Safety and Quality Improvement curriculum – this includes pre-course online training and assessments, workshops, and morning report. The ambulatory curriculum also includes one session on medical ethics by Dr. Ray Moseley, as well as Women's Health workshops and skills check-off session on simulated patients and a 'Breaking Bad News Workshop.

Emergency Medicine Rotation

Residents will work in the Emergency Department (ED) at both UF Health and the VA under the supervision of Emergency Medicine faculty to provide initial care to patients with a variety of medical and surgical presentations. This experience will involve only adult patients. Residents are typically required to rotate in the ED for 1 month total during their 3 years of training. Emergency Department shifts will not exceed 12 hours and will be separated by a period free of clinical duties for at least 10 hours. Residents are expected to receive both informal and formal teaching from Emergency Medicine faculty. Residents are expected to attend noon conference, Grand Rounds, and continuity clinic while on this rotation.

Evidence Based Medicine (EBM)

During each academic year, Residents will spend a half-month rotation on evidence based medicine (EBM). The first eight days of the rotation will be vacation time with the remaining time will be devoted to EBM. Residents have this time set aside to learn how to critically appraise medical literature, biostatistics and epidemiology.

During EBM, residents are expected to attend all morning reports and noon conferences/ Grand Rounds.

As EBM training: the residents will meet in 1-3 sessions, the first will consist of a didactic about EBM. Residents and Interns will be assigned a journal article and instructed to critically appraise the article during Monthly Journal Club.

Articles are standardized and chosen in advance by the Ambulatory Chief Resident and faculty attending Dr. Rebecca Beyth).

Attendance and performance of all expected aspects of EBM week is mandatory. Failure to do so will be viewed as a breach of professionalism and result in disciplinary action by the Housestaff Evaluation Committee.

Electives

Elective time is divided during each year of the residency. Typically, elective time increases as an individual advances through the residency program. However, there is no guarantee elective time will be equal for all Residents or necessarily increase over time. Electives are grouped into two major categories: Outpatient and Inpatient.

Elective requests are approved and scheduled by the Program Director and the Ambulatory Chief Resident. Below is the list of available electives. Changes to this list occur based on clinic and provider availability.

This list is frequently updated. Non-outpatient electives will be reviewed and approved by the Program Director and the Ambulatory Chief Resident. Requests for research time, away electives or any elective not listed on the Residency Homepage are subject to prior approval from the Ambulatory Chief resident and Program Director.

Choosing Electives: The Ambulatory Chief resident will send out elective requests one month prior to the elective time for the residents. All electives have *Goals and Objectives* as detailed in our curriculum and should be reviewed with an attending at the beginning of the rotation. Each elective will have a designated course supervisor who will be the attending to oversee the Resident's attendance, performance, and evaluation during that elective.

Outpatient	
VA Cardiology Clinics	Global Health Elective (Senior residents)
UFH Cardiology Clinics	Geriatric Elective
UFH Endocrinology Clinics	Primary Care Elective (senior residents)
UFH GI/Liver Clinics	Allergy/Immunology
UFH Pulmonary Clinics	Nephrology Clinic
Hem/Onc Clinics	Lung Transplant Clinic
Rheumatology Clinic	
Dermatology Clinic	
Sports Medicine	

Inpatient	
<i>VA Cardiology Consults</i>	VA ID Consults
UFH Cardiology Consults	UFH ID Consults
UFH Heart Failure (senior residents)	UFH Transplant ID (senior residents)
UFH Cardiology EP (senior residents)	VA Nephrology Consults
VA GI Consults	UFH Nephrology Consults
UFH GI/ Hepatology Consults	Transplant Nephrology Consults (senior residents)
VA Hem/Onc Consults	VA Pulmonary Consults
UFH Heme Consults	UFH Pulmonary Consults
<i>VA Palliative Care (senior residents)</i>	<i>UFH Radiology/Neurorads</i>
BMT Unit (senior residents)	<i>VA Radiology/Neurorads</i>
	<i>Rheumatology Consults</i>

Moonlighting Policy

Moonlighting is considered an optional activity which, if approved, must be contained within the work hour guidelines set forth by the ACGME. Averaged over a 4 week period, trainees are limited to 80 work hours per week, including in house call activities and moonlighting. Additionally, all house staff must have 10 hours free of duty between shifts. Under no circumstance will moonlighting be allowed to create a conflict of commitment with the Resident's core residency training program.

Residents may not engage in any moonlighting activities without written approval from the Program Director or Chief Residents. The program director has the discretion to decide, categorically or individually, whether or not the proposed moonlighting activity is compatible with the training program requirements of our program. Therefore, he may permit, prohibit, limit, or revoke permission to moonlight as he deems appropriate.

Moonlighting must not interfere with the ability of the Resident to achieve the goals and objectives of the educational program.

1. Moonlighting is only permitted at UF Health on the inpatient hospitalist service. Unapproved moonlighting elsewhere will be considered grounds for immediate termination.
2. All moonlighting hours must be recorded as duty hours, and logged in New Innovations. Failure to do so may result in corrective action and revocation of moonlighting privileges.
3. Moonlighting hours must not exceed the ACGME 80 hour work week or lead to any other ACGME work hour violations.
4. No moonlighting can interfere with the ability of the Resident to achieve the goals and objectives of the educational program.
5. Residents cannot moonlight while assigned to back-up.
6. Residents are NOT allowed to Moonlight overnight the night prior to their Continuity Clinic
7. Residents must attend all scheduled clinics, ward assignments, and activities on their current rotations.
8. Moonlighting Residents' progress and performance will be closely monitored, and any adverse effects on achievement of program goals and objectives may lead to revocation of moonlighting privileges.
9. Moonlighting is restricted to PGY-III Residents and PGY-II residents in the second half of their academic year only, AND who meet the following requirements:
 - a. Overall average conference attendance (Noon Conference & Morning Report) 70% or greater in the academic year.
 - b. Remain in good-standing with the program

- c. Scored greater than the 30th percentile overall on the most recent in-training exam (ITE)
- 10. The Chief Resident in charge will make a pre-approved list every month and inform the residents and the Hospitalist coordinator of their eligibility to moonlight.
- 11. Residents may only moonlight while on the following rotations:
 - a. Elective: Any Friday or Saturday shift. Weekday overnight moonlighting shifts are not permitted (including Sundays). You may work up to 2 swing shifts on the weekdays.
 - i. Max total moonlighting shifts per week: 3.
 - b. Ambulatory: Any Friday or Saturday shift. Weekday overnight moonlighting shifts are not permitted (including Sundays). You may work up to 2 swing shifts on the weekdays.
 - i. Max total moonlighting shifts per week: 3.
 - c. EBM or Vacation: No restriction on number or types of shifts
 - d. Research elective: Up to 3 shifts per week (weekdays are permitted as long as it's not the night prior to clinic).
 - e. Neuro Consults: No swing shifts M-F. Swing shifts can be worked Saturdays and Sundays. Overnight shifts on Friday and Saturday are permitted (no overnight shifts on Sundays)
- 12. Request forms:
 - a. A Moonlighting Policy Acceptance Form must be submitted to the Ambulatory Chief Resident prior to the first moonlighting shift.
 - i. Moonlighting activities performed without this may result in disciplinary action, not excluding termination and will be considered volunteering and thus withholding of reimbursement may occur.
 - b. A Moonlighting Request Form must be submitted to the ambulatory chief resident for each shift requested. These forms are found on the housestaff website or in the medicine office.
 - i. *For those with a work visa, there is a separate request form to fill out.
 - c. A Hospital Medicine - Extra Duty Sheet must be filled out for the MHS division to document the shift and hours worked.

Evaluation of Residents

Monthly faculty evaluation: Faculty are instructed to provide end of rotation evaluations of each Resident. This information is available at any time for the Resident to access online via New Innovations. Additionally, faculties are required to give formative feedback during the course of the rotation. This includes a mid-month review of Resident and Intern performance based on core competencies.

Clinical evaluation: Residents will be witnessed performing all or portions of patient encounters in a variety of settings, but especially during their continuity clinic, and given feedback on their performance.

Continuity Clinic evaluations: Each Resident will be evaluated by his/her continuity clinic preceptor every 6 months.

In –Training Exam: Residents are required to take the ITE in each of their years of training. This test is designed as a self-assessment tool for Residents to use in designing their educational course. It is also a strong predictor of future Internal Medicine Board (ABIM) performance. The results will be reviewed with the Resident during the semi-annual evaluation review, and the Resident's schedule may be modified to address identified knowledge deficits.

Residents who score <40th percentile will be assigned to an intense remediation (see section on remediation).

Semi-annual Evaluation Review: Every 6 months the program director or his designee will meet with each Resident to review his/her evaluations and progress in the program.

Housestaff Evaluation Committee: The Housestaff Evaluation Committee serves to review the performance of each Resident and to determine overall competence of the Resident. This committee makes recommendations to the program director related to the promotion of Residents and ultimately their board eligibility.

Performance Expectations: The Internal Medicine Training Program is based upon the concept of graded responsibility. Each Resident is expected to achieve certain performance milestones in order to pass to the next level of responsibility. The document serves to clarify the milestones and serve as a guide to further professional development. The milestones for the end of each year are grouped among the following areas: patient care, medical knowledge, leadership skills, teaching skills, procedural skills, system-based practice, practice-based learning and improvement, communication skills, and professionalism. The Housestaff Evaluation Committee will use Resident self-evaluation, faculty evaluations, peer evaluations, student and PCRM evaluations, and discussion with each Resident to determine whether these milestones have been met. It is the responsibility of the Housestaff Evaluation Committee to recommend promotion of each Resident to the next level of training, and the ultimate decision for promotion lies with the program director.

Professionalism

In accordance with the ABIM's Project Professionalism, the Internal Medicine Residency Program will expect every Resident to be professional. This includes and is not limited to the principles of expanding individual knowledge, a dedication toward service, altruism, autonomy, accountability, morality and integrity, and adherence to all ethical standards. Professionalism must begin as a Resident and be practiced toward fellow Residents, Attendings, staff and patients.

If at any time an Attending, Program Director, Chief Resident, Senior Resident (PGY 2 or PGY 3), or Intern feels a Resident is acting in an unprofessional manner, consequences may result. This can include and is not limited to speaking with a Chief Resident or Program Director, formal documentation in a Resident's personal file, reprimand by the Housestaff Evaluation Committee, suspension, or even dismissal. Unprofessional behavior will not be tolerated.

ACGME Core Competencies by Postgraduate Level

PGY-1

Professionalism: The Resident will demonstrate consistent behaviors that reflect respect, compassion, integrity, and altruism toward patients, families, and colleagues. This is fundamental to the practice of medicine and the foundation on which all other skills are built. Unprofessional behavior will not be tolerated.

Patient Care: The Resident will demonstrate an ability to obtain an appropriately detailed history and performing an appropriately detailed physical exam in inpatient and outpatient settings. The Resident must be able to interpret the data obtained and apply this in the form of an initial management plan.

Medical Knowledge: The Resident will demonstrate a basic understanding of the disease processes that commonly affect patients in inpatient and outpatient Internal medicine settings. The Resident will demonstrate this knowledge through performance on the Internal medicine in-training examination given in October of each year as well as in daily clinical activities supervised by senior Residents and faculty.

Leadership Skills: The Resident will display clinical competence to the extent that he (she) is capable of acting

as the team leader.

Teaching Skills: The Resident will provide teaching to the student(s) on service at a level appropriate to the learners' ability. This should include, but not be limited to, teaching of basic medical knowledge in the course of delivery of patient care.

Procedural Skills: The Resident will demonstrate knowledge of the indications for techniques and potential complications of procedures to include: paracentesis, thoracentesis, lumbar puncture, central line placement, arterial blood gas analysis, arterial line placement, pap smears/pelvic exams, rectal exams, and breast exams.

System-based Practice: The Resident will demonstrate a willingness to work with other members of the healthcare team to optimize the care of the patient. This includes the coordination of care with the PCRM to ensure that discharge planning needs are anticipated and addressed early in the course of an inpatient admission. The Resident will possess a basic understanding of what tasks are best performed by other members of the health care team to improve the efficiency and effectiveness of patient care.

Practice-based Learning and Improvement: The Resident will demonstrate an ability to reflect on his or her practice to define areas in need of improvement. The Resident will also utilize feedback from faculty, staff, and peers to analyze his/her patient care practices in an ongoing effort to improve. The Resident will also use the score on the in-training exam to reflect on areas of medical knowledge most in need of improvement.

Communication Skills: The Resident will be able to communicate clearly with patients, families, coworkers, and consulting services to improve the care for his (her) patients.

PGY-2

Professionalism: The Resident will demonstrate consistent behaviors that reflect respect, compassion, integrity, and altruism toward patients, families, and colleagues. This is fundamental to the practice of medicine and the foundation on which all other skills are built. Unprofessional behavior will not be tolerated. In addition to demonstrating professional behavior, the Resident will monitor their learners for signs of unprofessional behavior that might adversely affect patient care.

Patient Care: The Resident will demonstrate an ability to obtain a detailed history and physical examination including subtle findings. The Resident can analyze this data and use it to formulate a management plan for even complex inpatient and outpatient encounters. The Resident will also provide appropriate supervision of learners as judged by supervising faculty and the Resident's learners.

Medical Knowledge: The Resident will demonstrate medical knowledge sufficient to effectively lead a ward team and supervise Interns and students.

Leadership Skills: The Resident will be proficient at leading a team of healthcare providers in the inpatient setting.

Teaching Skills: The Resident will demonstrate appropriate teaching to students and Interns and foster the teaching skills of the learners.

Procedural Skills: The Resident will effectively perform and supervise procedures to include: paracentesis, thoracentesis, lumbar puncture, arterial puncture, blood gas analysis, central line placement, pap smears/pelvic exams, rectal exams, and breast exams.

System-based Practice: The Resident will work closely with the PCRM from the time of a patient's admission to

anticipate discharge needs and facilitate transfer of care to the outpatient or long-term care setting. The Resident will also demonstrate basic knowledge of the systems in which outpatient care is practiced including prescribing in accordance with a patient's prescription benefit plan and home care resources.

Practice-based Learning and Improvement: The Resident will demonstrate an ability to analyze the primary literature as systematic reviews of literature to practice evidence-based medicine. In addition to analyzing feedback from evaluators, the Resident will demonstrate an ability to reflect on his/her practice to identify and correct areas in need of improvement.

Communication Skills: The Resident will communicate effectively with patients, families, consultants, outside physicians, and staff to optimize the care of patients.

PGY-3

Professionalism: The Resident will demonstrate consistent behaviors that reflect respect, compassion, integrity, and altruism toward patients, families, and colleagues. This is fundamental to the practice of medicine and the foundation on which all other skills are built. Unprofessional behavior will not be tolerated. In addition to demonstrating professional behavior, the Resident will monitor their learners for signs of unprofessional behavior that might adversely affect patient care.

Patient Care: By the end of PGY-3, the Resident demonstrates an ability to manage complex patients and educate others on the team to enhance patient care.

Medical Knowledge: The Resident possesses detailed knowledge of complex medical conditions such that he/she is deemed by the program director to be sufficiently prepared for independent practice.

Leadership Skills: The Resident demonstrates the ability to lead a team of providers to provide excellent care for the team's patients.

Teaching Skills: The Resident demonstrates an ability to teach learners such as students and Interns effectively. The Resident also teaches colleagues at the same and higher levels. The Resident is required to demonstrate scholarly activity in the form of scientific research or in researching a topic to teach to his/her fellow Residents.

Procedural Skills: The Resident demonstrates technical competence and sufficient numbers of the procedures required by the ABIM for certification.

System-based Practice: The Resident understands the aids to and barriers to care and effectively advocates for the patient in both inpatient and outpatient settings.

Practice-based Learning and Improvement: The Resident consistently analyzes his/her practice patterns and strives to improve upon the care provided to patients. The Resident demonstrates reflective practice that will enable him/her to continually advance his/her medical knowledge and skills in practice.

Communication Skills: The Resident consistently demonstrates interpersonal and communication skills that serve to establish and maintain professional relationships with patients, families, and colleagues. The Resident will demonstrate these skills in the care of patients and also in the presentation of their scholarly activity to the residency program.

Departmental Discipline Policy

The Department of Medicine expects all Residents to fulfill their responsibilities and conduct themselves in a competent, professional manner, and to follow the rules, regulations and policies of the University of Florida and affiliated hospitals, as well as federal and state law.

In the event a Resident falls short of these expectations, and/or engages in misconduct, violates rules, or fails to satisfactorily perform in the training program, the Resident will be counseled and/or disciplined for his/her actions or inactions. Examples of such behavior include:

1. Poor clinical rotation performance
2. Failure to show up for assigned rotations/clinic
3. Resident substance abuse
4. Dishonest behavior
5. Criminal behavior
6. Unethical behavior
7. Repeated non-compliance with hospital policies (e.g. dictations, work hours)
8. Poor conference attendance
9. Inappropriate use of backup/sick leave

The Clinical Competency Committee (CCC) will address any deficits that are brought out in the Resident evaluations and make recommendations to the Program Director. Actions the CCC may include: remediation, probation, non-promotion, suspension, non-renewal, or dismissal. In the event of any adverse action against him or her, the Resident has a defined process for appealing the action (see "Appeals," below).

The steps involved in corrective discipline of a Resident include one or all of the following: verbal warnings, written warnings, probation, suspension, and/or termination. Depending on the circumstances of the Resident and the type of misconduct, the CCC, Program Director, and/or his designee(s) may choose any of the described disciplinary actions for a single infraction, including immediate termination from the training program.

Disciplinary Process

1. Verbal Warning

A verbal warning, which may be given to a Resident by a Chief Resident, Associate Program Director, or Program Director, is designed to identify a resident's minor or initial infraction of policies, standards, or expectations. The warning will be firm and fair, with the goal of assuring that the resident understands the policies, standards, and expectations. A written record of the date and content of the discussion, as well as the underlying situation which precipitated the warning, will be maintained in the resident's academic file.

2. Written Warning (Letter of Reprimand)

A written warning may be issued by the Program Director and the Chairman of the Housestaff Evaluation Committee. A written warning is appropriate when a prior verbal warning has not resulted in the needed improvement or when the initial misconduct violation or performance inadequacy indicates a need for action stronger than a verbal warning. The written warning should note the unacceptable conduct or action that caused the warning, as well as the program's improvement expectations. The written warning must be signed by the resident and a copy given to him/her. A copy must be placed in the resident's academic file.

3. Remediation:

In instances where the resident exhibits deficits in the areas of academic performance, a period of remediation may be the most appropriate course of action. If the HEC votes to impose a remediation period for the resident, the program director or his designee will meet with the resident to outline the problem areas along with a time period for remediation and an outline for the structure of the remediation. If the resident does not successfully complete the remediation program the program may consider a **prolongation of training or probation** after presenting all of the facts at a meeting of the HEC. Successful remediation will allow the Resident to continue training on schedule with no further effects on his/her career except for increased monitoring during the residency training.

4. Probation

In the event of egregious lapses in academic performance or unprofessional or unethical behavior, the resident may be placed directly on probation. The Program Director or the HEC may place a resident on probation when he/ she is unable to:

1. Meet the academic expectations of the training program (failing to progress at the expected pace);
2. Experiences a serious lapse in complying with the responsibilities of the program; or
3. Demonstrates other serious misconduct and/or performance problems.

Usually a resident will have one or more counseling sessions or receive a verbal or written warning about his/her deficiency prior to being placed on probation. In placing the resident on probation the Program Director/Chair of the HEC should:

1. Review the policies and expectations of the program
2. Identify the area of deficiency
3. Identify the improvement(s) that must be achieved during the probation period
4. Identify the length of the probationary period
5. Inform the Resident what action(s) may be taken if the stated improvements are not met in the established time frame.

In the event of a decision for probation by the CCC, the Program Director and the Chair of the CCC will meet with the resident to detail the accusations and present the Resident with the terms and duration of probation as well as the consequences of failure to meet the terms of the probation. A resident will receive this probation notification in writing. Copies of the probation notice will be placed in the residents' academic file. A probation period occurring during training will be noted in all letters of reference.

If the resident successfully completes the probation period without further problems, he/she will be returned to a non-probationary status. Failure to complete the terms of probation may lead to an extension of the probation period or possibly dismissal from the program.

Suspension, Nonrenewal, Dismissal and Procedure for Grievance

The position of the resident presents the dual aspect of a student in graduate training while participating in the delivery of patient care. For purposes of this policy, the term "resident" applies residents, fellows, and adjunct clinical post-doctoral associates in training programs recognized and approved by the Graduate Medical Education Committee (GMEC) at the University of Florida College of Medicine (COM). These training programs may be either ACGME Accredited Programs or non-accredited programs formally approved by the GMEC.

The University of Florida College of Medicine is committed to the maintenance of a supportive educational

environment in which residents are given the opportunity to learn and grow. Inappropriate behavior in any form in this professional setting is not permissible. A resident's continuation in the training program is dependent upon satisfactory performance as a student, including the maintenance of satisfactory professional standards in the care of patients and interactions with others on the health care team. The resident's academic evaluation will include assessment of behavioral components, including conduct that reflects poorly on professional standards, ethics, and collegiality. Disqualification of a resident as a student or as a member of the health care team from patient care duties disqualifies the resident from further continuation in the program.

Suspension: The Chief of Staff of a participating and/or affiliated hospital where the resident is assigned, the Dean, the President of the Hospital, the DIO, the Chair, the Division Chief or Program Director may at any time suspend a resident from patient care responsibilities. The resident will be removed from duty, informed of the reasons for the suspension, and given an opportunity to provide information in response.

During suspension, the resident will not provide patient care duties and access to the medical record and patient care areas will be suspended. They may be assigned to other duties as determined and approved by the Chair. The resident will either be reinstated (with or without the imposition of academic probation or other conditions) or dismissal proceedings will commence by the University against the resident within thirty (30) days of the date of suspension.

Any suspension and reassignment of the resident to other duties may continue until final conclusion of the decision making or appeal process. The resident will be afforded due process and may appeal for resolution as described below.

Nonrenewal: In the event that the Program Director decides not to renew a resident's appointment, the resident will be provided written notice which will include a statement specifying the reason(s) for nonrenewal.

Dismissal: In the event the Program Director and or Clinical Company Committee of a training program conclude a resident should be dismissed prior to completion of the program, the Program Director will inform the Chair of the decision and the reasoning. The resident will be notified and provided a copy of the letter of dismissal; and, upon request, provided documents that relate to the decision.

Grievances: A grievance is defined as dissatisfaction when a resident believes that any decision, act or condition affecting his or her program of study is arbitrary, illegal, unjust or creates unnecessary hardship. Such grievance may concern, but is not limited to, the following; academic progress, mistreatment by any University employee or student, wrongful assessment of fees, records and registration errors, discipline, termination and discrimination because of race, national origin, gender, marital status, religion, age or disability, subject to the exception that complaints of sexual harassment will be handled in accordance with the specific published policies of the University of Florida College of Medicine.

Prior to invoking the grievance procedures described herein, the resident is strongly encouraged to discuss his or her grievance with the person(s) alleged. This is not a required prerequisite to filing a grievance and does not act to extend the deadline to file a grievance, however good communication is oftentimes the best way to seek resolution as well as a good opportunity for practicing effective interpersonal skills in the learning environment. It is advisable to document such conversations in writing, and to seek the support and guidance of the program director and/or Graduate Medical Education (GME) Housestaff Director, as appropriate.

In cases where the situation remains unsatisfactorily resolved, the resident should proceed with filing a grievance. Each step of the grievance process must be filed within deadlines provided below. A grievance is considered filed at the time it is received from the person making the decision at each step of the grievance process. Failure to file a grievance within the time limits at any step of the grievance process shall be deemed a waiver of the resident's right to the grievance procedure and render any prior action or decision the final agency action of the University.

A non-renewal or dismissal may be grieved through Step 3 of the grievance procedure. All other acts or omissions may be grieved through Step 2 and the decision of the DIO will be the final agency action of the University.

Step 1: Step 1 grievance shall be initiated by the resident filing a written statement of the concern and issues that are the subject of the grievance with the Chair. The grievance must be filed within 10 working days from the date the resident was notified of the act, or 10 working days from the date the resident acquires knowledge, or could have reasonably been expected to have acquired knowledge, of the act or omission.

If the grievance meets the timing and substantive requirements, the Chair will meet with the resident. The Chair will make best efforts to schedule this meeting within 10 working days of receipt of the grievance. At the meeting, the resident may present relevant information regarding the basis for the grievance. An advisor may accompany the resident during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. The Chair will use his or her best efforts to present a written decision on the grievance to the resident within 10 working days of the meeting.

Step 2: If the resident is not satisfied with the Step 1 decision, the resident may file a Step 2 grievance with the Designated Institutional Official (DIO) within 5 working days after the Chair issues the Step 1 decision. The DIO will conduct a review of the action grieved, the Step 1 decision and other information relevant to the decision. If the DIO determines that a meeting with the resident is needed, he or she will use their best efforts to schedule the meeting within 10 working days of receipt of the Step 2 grievance. The DIO may uphold, modify or reverse the Step 1 decision. The DIO will use his or her best efforts to notify the resident in writing of the Step 2 decision within 10 working days following the meeting or 15 working days following receipt of the grievance if no meeting is held.

Step 3: If the resident is not satisfied with the Step 2 decision regarding non-renewal or dismissal, the resident may file a written Step 3 grievance with the Dean of the College of Medicine within 5 working days of the DIO's issuance of the Step 2 decision.

The Dean will inform the DIO of the Step 3 grievance. The DIO will provide the Dean a copy of the decision, accompanying documents and any other material submitted by the resident or considered in the grievance process. The Dean will conduct a review of the action grieved, the Step 2 decision and other information relevant to the decision. If the Dean determines that a meeting with the resident is needed, he or she will use their best efforts to schedule the meeting within 10 working days of receipt of the Step 3 grievance. The Dean may uphold, modify or reverse the Step 2 decision. The Dean will use his or her best efforts to notify the resident in writing of the Step 3 decision within 10 working days following the meeting or 15 working days following receipt of the grievance if no meeting is held but failure to do so is not grounds for reversal of the decision. In addition to the resident, the Dean will notify in writing the Chair, the DIO and the Program Director of the Step 3 decision. The decision of the Dean will be the final agency action of the University. The resident will be informed of the steps necessary for the resident to further challenge the action of the University.