

ST. MARY'S HEALTH CENTER HOUSESTAFF POLICY MANUAL
JULY 2014
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INTRODUCTION

The St. Mary's Health Center Internal Medicine Housestaff Training Program is an independent fully accredited program in Internal Medicine sponsored by SSM St. Mary's Health Center. St. Mary's is a major affiliate of St. Louis University Medical School and over 100 second, third and fourth year students rotate through the Department of Medicine during a typical academic year. The training program is headed by a full-time Program Director and a full-time Associate Program Director. The faculty includes Core full-time, Core part-time and adjunct faculty, all of whom are practicing Internists or practicing subspecialists.

The overall Goal of the Residency Program is the achievement of a level of performance in all competencies which is predictive of success as an independently practicing internist or as a fellow and is predictive of success on the ABIM certifying examination.

1. HOUSESTAFF ORGANIZATION

The Medicine housestaff consists of first year, second year and third year residents who are graduate physicians.

2. TERMS OF SERVICE

- (a) The Residency Program participates in the National Resident Matching Program (NRMP) and adheres to its procedural guidelines for accepting medical school graduates into the training program. Promotions and dismissals from the program are made by the Program Director on recommendation of the Resident Clinical Competency Committee.
- (b) The Residency Program adheres to all current ACGME and Internal Medicine guidelines and requirements, including all work rules.
- (c) All housestaff are granted 21 vacation days each academic year. Vacations are subject to approval and scheduled by the Department of Medicine and the specific dates will be chosen so as not to interfere with the resident's educational experience. Please refer to Appendix A: "How to Count Vacation Days" for a full explanation. Please note that vacation leave must be taken, per ABIM, and cannot be forfeited or used to abbreviate the duration of training, for any reason, including late start, extended illness, or parental leave.
- (d) With regard to Time Off, the ABIM is very explicit in stating that time off for any reason—vacation, illness, parental leave, etc., paid or unpaid—cannot exceed 3 months during the 36 months of training required for Board eligibility. Any time away from training exceeding 3 months must be made-up by extending the period of residency training. We use 3 months or 90 days. As vacation time in our program is 3 weeks per year

(21 days), then the additional time available is calculated as 90 days (-) 63 days = 27 days or approximately one month.: thus, in our program, following RRC rules, a resident can take up to one month off for parental leave or illness, or approved leave of absence (but no more), whether with pay or without, and still graduate on time. Standard paid maternity leave is 4 weeks. Standard paid paternity leave is one week unless the mother is unable to care for the newborn due to illness. In this case, paid paternity leave can be extended to up to 4 weeks. Federal FMLA rules allow up to 12 weeks parental leave after 12 months of employment. All unused paid vacation must be used first and the remainder of the 12 week leave of absence will be unpaid. Any approved absence beyond one month during the 36 months must be made up by extending training.

- (e) House officers may NOT ENGAGE IN EMPLOYMENT OUTSIDE OF THE HEALTH CENTER SYSTEM. Third year residents with a permanent license may work in the Emergency Department or with the Hospital Medicine Department at this facility with the following restrictions.
- (1) Approval of the Program Director and the specific Director of the ED or Director of Hospital Medicine.
 - (2) No more than **TWO 12 hour weekend** only shifts per block and no more than one weekend shift per week when on an elective. No ED shifts are to be taken while on an ICU rotation or on a primary floor rotation. An ED shift cannot extend the work hours beyond **80 hrs** per week nor can the “**10 hr rule**” nor the “**24 hr rule**” be violated. A full day off per week must be taken and no ED or hospital medicine shift can be scheduled on that day.
 - (3) Employment in the Emergency Department or with Hospital Medicine MUST NOT interfere with the house officer's program responsibilities.
 - (4) It is important to note that the hospital's professional liability insurance DOES NOT PROVIDE COVERAGE for our ED nor for hospital medicine nor for outside the Health Center except for rotations that are part of the program.
 - (5) Working in the ED or on hospital medicine is a privilege not a right.
 - (6) Unapproved employment outside of the program will result in immediate dismissal from the program as it represents a breach of the residency program contract.

- (f) On successfully completing training, each house officer receives a certificate signed by the Program director and other appropriate individuals.
 - (f) **MEDICAL RECORDS delinquency**, if persistent, can result in probation and dismissal from the Program. It is your individual responsibility to maintain up to date records via your “In Basket” within the EPIC electronic medical record. IF A RESIDENT’S MEDICAL RECORD DEFICIENCY RESULTS IN AN ATTENDING PHYSICIAN LOSING ADMITTING PRIVILEGES THEN THAT RESIDENT WILL BE PLACED ON PROBATION FOR DEFICIENCIES IN PROFESSIONALISM AND PATIENT CARE.
3. SUPERVISING (Second Year [Junior] and Third Year [Senior]) RESIDENT RESPONSIBILITIES
- (a) Supervising Residents are responsible for supervising and directing the activities of the first year residents and medical students in the performance of their duties on the covered service.
 - (b) They are responsible for placing an appropriate supervising resident note on the chart of every patient admitted to their service. Together with the private physician, they are responsible for the care of the patients on their service. **THEY ARE THE LEADERS OF THEIR TEAM.** All medical students’ and first years’ notes must be reviewed and signed on a daily basis
 - (c) They have primary responsibility for the educational activities of their floor team including, conducting organized teaching rounds in the morning, chart rounds in the afternoon, assuring attendance at scheduled rounds and conferences, and reviewing first year resident and student work-ups.
 - (d) Third year residents, because of their additional experience, are expected to play a more significant administrative and educational role. Patient care and teaching responsibilities increase with increasing experience.
 - (e) Total PGY2 or PGY3 service size when supervising a single PGY1 on primary general medicine rotations should be limited to 14 patients. When a PGY2 or PGY3 is supervising 2 PGY1s, then the service size will be limited to 14 patients. In the Intensive Care Unit when supervising three or more PGY1s, total service size should not exceed 16 patients.

- (f) Second and third year residents on the floor and elective rotations take call two to four days per month in the ICU covering the PGY-1 ICU resident from 7:00 p.m. to 7:00 a.m. Monday through Friday evenings with sign-out beginning at 6:30 p.m.; Saturday and Sunday call starts at 1:30 p.m. and extends until 7:00 a.m. the following morning.
- (g) Floor/Night: The junior or senior resident will supervise a Night Float intern and will cover admissions and other housestaff responsibilities 7:30 p.m. until 7:00 a.m. six days per week. The Night Float resident must attend morning report daily but must be excused by 9:30a.m. All shifts are limited to total work time of 24 hours.
- (h) ICU/Night Float Team: Consisting of the nighttime ICU intern and cross-covering resident will cover ICU admissions and patient care responsibilities from 7:00 p.m. to 7:00 a.m. six days per week. The ICU/Night Float team will sign-out at 6:30 a.m. daily.

4. FIRST YEAR RESIDENT (Intern) RESPONSIBILITIES

- (a) First year residents are subject to supervision and direction by the second and third year supervising resident, and attending physician of record for each patient assigned to them.
- (b) When notified of a patient admission, the first year resident is to visit the patient AS SOON AS POSSIBLE AND IS TO RECORD THE REQUIRED COMPLETE HISTORY AND PHYSICAL EXAMINATION IN THE MEDICAL RECORD WITHIN 12 HOURS OF ADMISSION. If a rectal or pelvic exam are not performed at admission they should be recorded prior to discharge and if not performed a reason must be documented.
- (c) The first year residents are responsible for daily progress notes. Students can write daily progress notes, but they must be reviewed and co-signed on the day they are written.
- (d) The first year resident is responsible for maintaining an active problem list establishing that those tests ordered are performed and recorded in EPIC. The first year resident can consider drawing any STAT blood work that they order on their patients if the phlebotomy service delay is excessive in emergent situations.
- (e) First year residents are responsible for entering all orders on the patients on his or her service, under the supervision of the supervising resident and the attending physician. Orders that represent a major change in therapy or that might expose the patient to significant potential morbidity should be reviewed with the supervising resident and the private attending physician.

Supervising residents may assist PGY1 residents in entering orders on their patients but should make every effort to have the PGY1 resident enter all orders. The attending physician is actively discouraged from entering any orders on patients on the teaching service except under urgent circumstances or as a courtesy to the housestaff. Third year student history and physicals do not substitute for first year resident history and physicals in the medical record.

- (f) Total PGY1 service size on primary general medicine rotations should be limited to an average of 6 patients per PGY1 resident and should not exceed 10 patients..

In the Intensive Care Unit, total service size should not exceed 5 patients per PGY1 resident.

(Also see General Policies (d) regarding admission limits.)

- (g) The first year resident is responsible for maintaining an active problem list establishing that those tests ordered are performed and recorded in EPIC. He or she is responsible for establishing that PELVIC and RECTAL examinations are performed on patients, when appropriate. The first year resident can consider drawing any STAT blood work that they order on their patients if the phlebotomy service delay may be excessive in emergent situations.
- (h) First year residents round with their supervising resident(s) and their attending physician(s) as scheduled.
- (i) First year residents are responsible for notifying their supervising resident and the private physician of ANY major change in the condition of the patients on their service. Upon the death of a patient, the first year resident **MUST IMMEDIATELY NOTIFY THE SUPERVISING RESIDENT AND THE PHYSICIAN OF RECORD.**
- (j) Upon the death of a patient, the first year resident **WILL MAKE EVERY EFFORT TO OBTAIN AN AUTOPSY**, with the assistance of a supervising resident and the attending physician. Note that post-mortem examinations on the teaching service are performed without charge to the patient and family.
- (k) Patients can only be discharged by the first year resident on order of the attending physician of record. The supervising resident **MUST** be notified in advance of all discharges.
- (l) First year residents **SHARE** responsibility with the supervising residents for the supervision and teaching of the 3rd year students assigned to them.

All student notes must be reviewed, amended as appropriate, and co-signed. Third year student History and Physicals are not a substitute for PGY-1 History and Physicals as they are not a part of the permanent record.

- (m) All procedures must be supervised by a second or third year resident or attending physician credentialed in the procedure.
- (n) Night Float interns accept responsibility from 4:30p.m. to 6:30a.m. on Floor and 6:30a.m. to 6:30p.m. in ICU. Shifts never exceed 16 hours of continuous duty, require 8 to 10 hours off and are limited to 80 hours per week with a full day off just as the standard Floor or ICU rotation.

5. MEDICAL STUDENT RESPONSIBILITIES

- (a) Refer to the Student Orientation Packet available in the Department of Internal Medicine.

6. ATTENDING PHYSICIAN RESPONSIBILITIES

- (a) Attending physicians who admit their patients to any teaching service are responsible for the supervision and education of the residents assigned to their patients. All recommendations and changes in care should be effected through the PGY1 residents and the assigned supervising resident. Attending physicians should make every effort to avoid entering any orders on patients on the teaching service. Attending physicians who serve as subspecialty consultants for patients on the teaching service also have supervisory and teaching responsibility for the residents assigned to the patient on whom they are consulting. They should review their impressions and recommendations with the housestaff and should make every effort to allow the housestaff to enter the orders implementing their recommendations. Teaching attending's major responsibility, second only to patient care, is the clinical education of residents on their service, utilizing the patients on the service. They should also recognize their role as mentors and role models to the residents on the service.

7. TRIAGE RESIDENT RESPONSIBILITIES

- (a) All supervising residents assigned to the general medicine floor function as the Triage Resident on their assigned day.
- (b) The Triage Resident works with the admitting physician, the Emergency Department, the house supervisor and bed placement services in accepting and assigning patients to the covered service and evaluates proposed transfers from other areas of the hospital, prior to their being moved to covered medicine.

- (c) A consult to the Internal Medicine Teaching Service must be entered on every patient at the time of acceptance onto the covered medicine service.
- (d) The triage function is acquired by the supervising resident On-Call on evenings and weekends.

8. GENERAL POLICIES (including Duty Hours)

- (a) Official in-house duty hours for residents and students are determined according to the service to which they are assigned. The standard time of in-house duty is 6:00 a.m. to 5:00 p.m. Monday through Friday.

SMHC adheres without exception to all current ACGME/IM RRC work rules. Scheduled work weeks will not exceed 80 hours/week, **averaged over 4 weeks**, on any rotation. Elective work weeks will generally average 40-50 hours/week. Duty responsibility is always patient care dependent and MAY REQUIRE ARRIVING EARLIER AND STAYING LATER but in no case will PGY2 or PGY3 residents be on duty for greater than 24 consecutive hours nor a PGY1 intern be on duty for greater than 16 hours, or be off for less than 10 hours, except as specifically approved by the IM RRC.

Each resident will have one full day off per week **averaged over four weeks.**

- (b) ALL RESIDENTS are expected to be on time and participate in all scheduled teaching conferences. If attendance falls below 70% (or a level adjusted specific rotations) then counseling will be provided and could lead to academic probation. If they are unable to attend, the office **MUST BE NOTIFIED.**
- (c) Duty hours must be submitted each week through the MyEvaluations system.
- (d) PGY1 admissions on General Medicine Floor or ICU rotations are limited to 5 new patient admissions (plus two intra-service transfers on Floors) per 24 hour period or 8 new admissions for any 48 hour period. In unusual circumstances, when the on-call team finds it necessary to exceed these limits, the supervising PGY2 or PGY3 resident may admit up to 3 additional new patients without the participation of the PGY1 resident (on teams with only one PGY1 resident.) [See service size limits 4(d)] PGY2 or PGY3 admissions are limited to 8 new patients per 24 hr. period or 12 patients in any 48 hour period. [See Service Size Limits 3(e)]

- (e) **It is the responsibility of the resident to notify the Department of Medicine AND the Chief Resident, as early as possible, in the event of an illness or circumstance that will prevent him or her from carrying out his or her assigned responsibilities. The resident must personally phone the department AND phone or text the Chief Resident. Absence for illness greater than 2 days requires a treating physician's written note.**
- (f) Coverage for an absent resident can only be arranged with approval and/or direction of the Program Administrator or Chief Resident.
- (g) IN NO CASE WILL MEMBERS OF THE HOUSESTAFF CROSS COVER FOR ONE ANOTHER WITHOUT NOTIFICATION OF THE CHIEF RESIDENT. The only exceptions to this rule are routine cross coverage for clinic responsibilities.
- (h) Whenever leaving or returning to the hospital (during duty hours), except for scheduled continuity clinics or electives, each member of the housestaff **MUST** notify the Medicine office and the telephone operators.
- (i) Beepers **MUST** be carried whenever responsible for patient care. They must be maintained in good working condition at all times; this includes updated pager prompts. **Lost beepers will be the financial responsibility of the resident in question.** The Medicine office and telephone operators **MUST** be notified if a beeper is not working to receive a replacement. For cross coverage on vacation or trips outside the covered area (approximately 1 hour drive-time radius), the pager prompt must include the dates you are away and the name and number of the person responsible for your calls while you are away.
- (j) Pagers must be signed out to the appropriate covering resident during your day off and when you are post call.
- (k) The Program Director may limit the number of house officers who leave the hospital at any one time.
- (l) Patients on the covered medical service will not be transferred to an uncovered service without notification of the patients' attending physicians. A progress note to this affect must be documented in the medical record at the time of the transfer of care. The consult to the Internal Medicine Teaching Service should also be discontinued at this time.
- (m) Subspecialty consultations and major diagnostic and therapeutic plans or orders (i.e. MRI) should not be initiated without consent of the primary attending physician. Consultant's recommendations should be called to

the attention of the primary physician and should be carried out only with the consent of the primary physician.

- (n) All residents and students are expected to make rounds on their assigned patients **AT LEAST TWICE DAILY** and to record an appropriately complete progress note outlining the patient's course on a daily basis and to maintain a problem list in EPIC on each patient. All student notes must be reviewed, annotated and signed by a house officer on the day they are written.
- (o) Professional attire is in order at all times. This "dress code" will definitely be enforced:

MEN – Collared shirt with or without tie, business/casual slacks with CLEAN and pressed lab coat.

WOMEN - Dress, blouse and skirt (appropriate business length) or appropriate slacks with CLEAN and pressed lab coat.

Jeans are only to be worn on the weekends when you are not on call or admitting patients. Running shoes are not appropriate footwear with the above. Sandals must be worn with socks or stockings.

Scrubs (with running shoes if desired as long as they are consistent with hospital safety policy, reproduced below) may be worn **ONLY** when on call and in the ICU.

“To protect healthcare providers from injury related to blood borne pathogen exposure via sharps or splashes, clean closed professional shoes are required. Canvas shoes, shoes with holes and/or open toes are not acceptable. To prevent injury related to falls, footwear should have slip resistant soles.”

9. ROTATION SPECIFIC POLICIES:

(a) Clinic – See the Clinic Policy Manual.

(b) Emergency Department –

Floor Residents can only care for patients boarding in the ED if:

- (1) An Internist has accepted responsibility for the patient in the ED.
- (2) The Internist has requested Teaching Service coverage.
- (3) The Triage resident has accepted the patient.
- (4) There is open and direct communication with the ED attending regarding any major changes or therapies to the patient's care or their clinical situation, especially when the patient will remain in the ED

for an extended period of time during which the ED attending still has some responsibility for the patient.

Intensive care unit residents can only see ICU patients in the emergency department if the following criteria are met:

- (1) The intensivist is consulted by the attending physician.
- (2) The intensivist directs the ICU resident to see the patient in the emergency department.

(c) Medical Floor –

- (1) PGY1 residents shall see/examine their patients and be ready for morning rounds by 7a.m..
- (2) On Saturdays, Sundays and National holidays, PGY1 residents should be present by 7a.m.
- (3) After completing weekend rounds, PGY1 residents must contact their senior residents or the resident On-Call that day to discuss ALL of their patients. (If there is an acute issue with a patient, then the On-Call resident should be notified immediately to assist with the management.)
- (4) All patients should be signed out to the PGY1 on **call no earlier than 4:00p.m** so as not to inappropriately overburden the cross-covering PGY1.
- (5) Third-year students should follow the PGY1 resident, while the fourth year students should follow the PGY2/PGY3.
- (6) All third-year student H&P's MUST be followed by a complete Resident H&P; fourth-year student, sub-intern, notes may be followed by a supervising resident addendum.

(d) Night Float Patient Allocation –

- (1) The first 3 patients admitted by NF should be picked up by the short-call team.
- (2) Any remaining patients will be assigned to the On-Call team.
- (3) Clinic patients assigned to the clinic resident's team if possible.
- (4) Patients previously admitted to a **current** floor team, readmitted during the same month, should be assigned to the same floor team regardless of their call status.

(e) ICU Guidelines –

- (1) All interns must have seen their patients and be ready to present them at 7:30a.m.
- (2) Service size should be limited to 5 patients/PGY1 resident (except in rare circumstances/weekends).
- (3) Total ICU size should not exceed 16 patients.
- (4) Post overnight call interns should leave the hospital in time to have at least 10 hours of free time away from the hospital.

- (5) On weekdays, the On-Call senior resident **MUST** be present in the ICU by 6:30p.m. to have a formal (30 min.) sign-out by the ICU resident. (On weekends, the On-Call senior resident **MUST** be present by 1:30p.m.)
- (6) Night intern in the ICU **MUST** be present in the ICU by 6:30p.m. every day for formal sign-out rounds.
- (7) All changes in the Call Schedule must be approved by the Chief Resident.
- (8) ICU TRANSFER OUT –
 - (i) Transfers out of the ICU should be accepted by floor teams until 2:30p.m. on weekdays (any patient transferred after 2:30p.m. will be picked up by the short-call team).
 - (ii) On Saturdays, short-call accepts ICU patients until 10:30a.m.
 - (iii) On Sundays, all ICU transfers are picked up by the on-call team.
 - (iv) A complete “acceptance note” may be written for patients transferred to the ICU from the teaching service (with an H&P). All other ICU transfers are required to have a complete History and Physical upon ICU admission.
 - (v) A complete acceptance note must be entered for all patients transferred from the ICU to the teaching service irrespective of the time of transfer.

10. RELATIONSHIP BETWEEN HOUSESTAFF AND THE PRIVATE STAFF

- (a) When treating a private patient, the house officers are expected to keep in close touch with the attending physician.
- (b) The house officer must notify the attending physician of any significant changes in the patient's condition and should discuss major diagnostic and therapeutic plans before they are initiated.
- (c) In emergency situations, the patient should be treated at the discretion of the responsible resident with the attending physician being notified **AS SOON AS POSSIBLE**.
- (d) Except in unusual circumstances, all orders on the covered service should be written by the house officer primarily responsible for the patient, in most cases, **THE FIRST YEAR RESIDENT**.
- (e) Resident responsibility for patients outside of the teaching service is limited to emergency coverage during a code blue or when called by the Emergency Response Team (ERT). All subsequent management is the responsibility of the attending physician unless the residents accept the patient in transfer to the teaching service. (See Appendix D, SMHC Policy on Internal Medicine Housestaff Coverage of Uncovered Services, for specific examples).
- (f) Admissions to the covered service are assigned by the **TRIAGE RESIDENT** or the "on-call" admitting resident.
- (g) Phone calls to private physicians should be made by the housestaff. It is **NOT** appropriate for third year medical students to call the private

physician unless the resident is on the line. It is at the discretion of the PGY-2/PGY-3 resident to determine if a fourth year medical student should discuss cases with the private attending.

11. MEDICAL RECORDS

- (a) The maintenance of accurate, **TIMELY** and complete medical records is a critical component of quality patient care and is an important responsibility of the housestaff.
- (b) Admission history and physicals should contain the following information:
 - 1. Chief complaint
 - 2. Present illness
 - 3. Past history
 - 4. Family history and social history
 - 5. Complete review of systems (eleven systems)
 - 6. Complete physical examination
 - 7. Complete listing of diagnoses and/or problems in order of priority
 - 8. A discussion and a carefully developed plan

Use of the H&P Template (via “NoteWriter”) in the EPIC electronic medical record is required. Before completing the NoteWriter template and signing your notes, the problem list and past history component must be completed for an accurate H&P.

- (c) An off-service/transfer note is to be written in the chart of any patient transferring to a new house officer. At a minimum, this should include summary of hospital course, current medications, outstanding tests or procedures, current attending and subspecialists involved, and current impression and **PLANS**. The receiving house officer is also responsible for a transfer/accept note with comprehensive summary and impression and plans. This includes the transfer of patients between house officer switching to/from Night Float.
- (d) All verbal orders must be signed **ASAP** or within 24 hours.
- (f) Orders must be reconciled when patients are transferred to or from the ICU or from an uncovered service to a covered service.
- (g) Daily progress notes should be dated and timed and include a summary of the patient's complaints, physical findings, relevant new laboratory information and an impression and **PLAN**.
- (h) Dictation of discharge summaries is the responsibility of the first year resident.

(i) Other documentation regulations:

1. Residents must co-sign all medical student entries AFTER CAREFULLY READING AND MAKING APPROPRIATE CHANGES AS NECESSARY.
2. Only approved abbreviations as included in the attached list are acceptable in the medical records.
3. History and physical examinations must be placed in the medical record within 12 hours following admission of patient. If a patient is readmitted within one month's time, an abbreviated history will be sufficient.

(j) INCOMPLETE RECORDS POLICY:

1. Delaying completion of records compromises patient care and delays patient and hospital reimbursement.
2. Hospital records should be completed on the day of patient discharge and MUST be completed with 14days of discharge.
3. Medical Records Completion Policy

-It is the responsibility of each resident to complete their medical records as assigned in their In-Basket with each login into EPIC.

-After 21 days without a Program Director approved reason (appropriate effort, illness etc) the resident will be penalized by being removed from their rotation and assigned to medical records to complete delinquent records. The jeopardy resident will be called in to replace the resident who will pay back the jeopardy during their elective time.

-Persistent delinquency will result in academic probation with counseling and a remediation plan. Failure to successfully resolve the probation can result in dismissal. It is a resident's individual responsibility to maintain up to date records via your "In Basket" within the EPIC electronic medical record. IF A RESIDENT'S MEDICAL RECORD DEFICIENCY RESULTS IN AN ATTENDING PHYSICIAN LOSING ADMITTING PRIVILEGES THEN THAT RESIDENT WILL BE PLACED ON PROBATION FOR DEFICIENCIES IN PROFESSIONALISM AND PATIENT CARE.

-Medical record completion is a requirement for Graduation.

12. TRAINING REQUIREMENTS (ROTATIONS)

- (a) Required rotations over 3 years (Note: all subspecialty rotations are but are interchangeable)

ACADEMIC CURRICULUM – PGY1

1	Neurology (vacation – 1 week)	4 weeks
2	Elective 1 month (vacation – 1 week)	
3	Block Ambulatory (vacation – 1 week)	4 weeks
4	4ICU	4 weeks
5	4ICU	4 weeks
6	4ICU	4 weeks
7	4ICU	4 weeks
8	Floor/Night Float	4 weeks
9	Floor/Night Float	4 weeks
10	Floor	4 weeks
11	Floor	4 weeks
12	Floor	4 weeks
13	Floor (Categorical) Selective (Preliminary)	4 weeks

ACADEMIC CURRICULUM – PGY2

1	Rheumatology Orthopedics*	4 weeks
2	ENT (1 week) Allergy* (1 week)	4 weeks

	Gynecology* (1 week)	
	Ophthalmology (1 week)	
3	Block Ambulatory/Geriatrics	4 weeks
4	Cardiology	4 weeks
5	Pulmonology	4 weeks
6	Nephrology	4 weeks
7	ICU	4 weeks
8	Floor/Night Float	4 weeks
9	Floor/Night Float	4 weeks
10	Floor	4 weeks
11	Floor	4 weeks
12	Floor	4 weeks
13	Elective	4 weeks

*Systems Based Practice

ACADEMIC CURRICULUM – PGY3

1	Endocrinology	4 weeks
2	GI	4 weeks
3	Infectious Disease	4 weeks
4	Dermatology* (2 weeks)	
	Psychiatry* (2 weeks)	
4	Emergency Department	4 weeks
6	Block Ambulatory/Geriatrics	4 weeks
	(vacation – 1 week)	
7	Hematology/Oncology	4 weeks
8	Medical Consult	4 weeks

9	ICU	4 weeks
10	Floor/Night Float	4 weeks
11	Floor	4 weeks
12	Floor	4 weeks
13	Elective	4 weeks

* denotes inclusion of one day devoted to Systems Based Practice experience

Half day per week Ambulatory Clinic is attended during all rotations except ICU (PGY1) and Night Team Floor Rotation. An elective performed within 30 miles of the St. Louis city limits does not exempt a resident from clinic, jeopardy call or ICU cross coverage. Residents performing electives outside of this radius are required to make up both jeopardy call and ICU cross-coverage shifts distributed through the remainder of the year.

Please note that there is a maximum of TWO (2) outside rotations allowed during a 36 month residency.

13. COMPETENCY-BASED CURRICULUM

The educational goals of the program organized around COMPETENCIES WITH SPECIFIC GOALS are contained in a written Internal Medicine Curriculum that is provided online on our Intranet. **The general “Core Competencies” are Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-based Practice. Other specific, so-called, “Secondary competencies” including Teaching, Leadership and Organizational Skills may be required depending on the goals of specific program requirements.**

COMPETENCIES DEFINED:

Patient Care

- Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:
- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families

- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- Develop and carry out patient management plans
- Counsel and educate patients and their families
- Use information technology to support patient care decisions and patient education
- Perform competently all medical and invasive procedures considered essential for the area of practice
- Provide health care services aimed at preventing health problems or maintaining health
- Work with health care professionals, including those from other disciplines, to provide patient-focused care

Medical Knowledge

- Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:
- Demonstrate an investigatory and analytic thinking approach to clinical situations
- Know and apply the basic and clinically supportive sciences which are appropriate to their discipline

Practice-based Learning and Improvement

- Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:
- Analyze practice experience and perform practice-based improvement activities using a systematic methodology
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- Use information technology to manage information, access on-line medical information, and support their own education
- Facilitate the learning of students and other health care professionals

Interpersonal and Communication Skills

- Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates. Residents are expected to:
- Create and sustain a therapeutic and ethically sound relationship with patients
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Work effectively with others as a member or leader of a health care team or other professional group

Professionalism

- Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:
- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Demonstrate sensitivity and responsiveness to patient's culture, age, gender, and disabilities

Systems-based Practice

- Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:
- Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for quality patient care and assist patients in dealing with system complexities
- Know how to partner with health-care managers and health-care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

14. The Evaluations system (to be updated July 2014)
15. REQUIREMENTS FOR PROMOTION—COMPETENCY AND SUB COMPETENCIES (MILESTONES) BASED

Residents are promoted based on the following expectations for each of the 6 core competencies plus Leadership, Teaching, and Organizational (administrative) skills. Achievement of the sub competencies is required to develop on a continuum with promotion based on achievement of specific sub competencies at each stage of training.

Patient Care:

PGY1 to PGY2: Mastering of basic H&P skills, sophisticated differential diagnosis, relatively independent development of differential diagnosis, independent basic diagnostic and therapeutic plan development, and demonstration of compassion and sensitivity to patient and family needs. Passage of the PGY1 Clinical Competency Exam (CEX) or its equivalent (e.g. “Mini” CEXs.)

PGY2 to PGY3: Demonstration of greater independence and sophistication in all patient care skills, requiring minimal attending level intervention (correction), more sophisticated patient interaction with consistent attention to health promotion strategies. Passage of the PGY2 CEX or equivalent.

PGY3 to Graduate: Demonstration of sophisticated, independent, confident patient care skills without necessity of attending physician intervention. Passage of the PGY3 CEX.

Medical Knowledge:

PGY1 to PGY2: Acquisition of basic clinical knowledge allowing development of a moderately sophisticated differential diagnosis, moderately sophisticated diagnostic and therapeutic plans, and effective, reliable medical student, PGY1, nurse, and patient education.

PGY2 to PGY3: Demonstration of a larger, more sophisticated, more reliable (accurate), more functional data base of clinical and pathophysiologic knowledge allowing more sophisticated patient care, more sophisticated and more formal educational contributions, and allowing for more effective personal growth. Passing score on the USMLE III examination.

PGY3 to Graduate: Demonstration of a mature, very sophisticated clinical knowledge base with a broader understanding of biomedical data, medical statistics, and human behavior allowing for very sophisticated patient care, teaching, and communication.

Practice-based Learning:

PGY1 to PGY2: A basic understanding of and commitment to critical self-assessment, critical assessment of clinical/scientific evidence, and a

sense of how these activities are important to continuous improvement in patient care.

PGY2 to PGY3: Demonstration of ongoing, active use of point-of-care clinical and scientific educational resources to continuously examine and improve knowledge and patient care, active involvement in self-assessment and self-improvement activities, and the ability to role-model and teach these skills.

PGY3 to Graduate: Demonstration of both a sophisticated understanding and practice of practice-based learning and a commitment to this competency as a life-long learning activity.

Interpersonal and Communication Skills:

PGY1 to PGY2: Basic but effective ability to interact and collaborate with patients, families, trainees, peers, attending physicians, and other health professionals.

PGY2 to PGY3: Demonstration of more sophisticated and more independently effective interpersonal and communication skills.

PGY3 to Graduate: Demonstration of very effective interpersonal and communication skills, the ability to model and teach these skills, and the ability to effectively and independently manage conflicts.

Professionalism:

PGY1 to PGY2: Demonstration of professional reliability and trust-worthiness and consistently ethical and non-discriminatory behavior.

PGY2 to PGY3: Continued demonstration of professional reliability and trust-worthiness, and consistently ethical and non-discriminatory behavior.

PGY3 to Graduate: Continued demonstration of professional reliability and trust-worthiness, and consistently ethical and non-discriminatory behavior, plus the commitment, when the situation arises, to place a patient's needs above their own.

Systems-based practice:

PGY1 to PGY2: A basic understanding of our health care system and an understanding of the multidisciplinary system resources that can be utilized to optimize the quality and cost-effectiveness of care.

PGY2 to PGY3: Demonstration of a functional understanding of the broader context and complexity of our health care system and the different types of payer systems, and the use of available resources including clinical pharmacists, case-management, social services and home care in optimizing the quality, and cost-effectiveness of their patient's care.

PGY3 to Graduate: Demonstration of the incorporation of a systems-based approach into their clinical practice.

Leadership:

PGY1 to PGY2: Demonstration of interpersonal skills and interactions with members of the health-care team that is predictive of effective leadership.

PGY2 to PGY3: Demonstration of effective leadership as a supervising resident.

PGY3 to Graduate: Demonstration of effective, independent leadership, and the ability to stimulate and support members of the team to provide optimal patient care using all available resources.

Teaching:

PGY1 to PGY2: Demonstration of a commitment to teach all members of the health-care team, patients and their families.

PGY2 to PGY3: Demonstration of effective role-modeling and effective teaching, both formal and informal.

PGY3 to Graduate: Demonstration of growth and sophistication in teaching skills and teaching effectiveness, and the development of a stimulating, intellectually-honest atmosphere of academic interaction among members of their team.

Organizational skills:

PGY1 to PGY2: Demonstration of basic ability to organize activities in such a way as to allow for effective patient care, fulfill professional obligations, pursue self-improvement activities, and fulfill personal obligations and needs.

PGY2 to PGY3: Demonstration of the ability to effectively manage their own time and also effectively manage their team activities.

PGY3 to Graduate: Demonstration of organizational and management skills that will adequately support their future professional activities.

16. CERTIFICATION REQUIREMENTS

- (a) For specific certification requirements, you should refer to the current Directory of Residency Training Programs manual published by the Accreditation Council for Graduate Medical Education.
- (b) The American Board of Internal Medicine currently requires that a clinical competency examination (CEX) be given each academic year. This has taken the form of an observed history and physical exam supervised by a member of the faculty and administered to all first, second and third year residents on a yearly basis. Any resident receiving an unacceptable evaluation will be retested by a member of the Resident Evaluation and Promotion's Committee. Failure on retesting will require remediation and retesting. Promotion requires successful passage of the CEX as a component of the Patient Care competency.
- (c) The American Board of Internal Medicine has recommended that Program

Directors have documentation of a resident's competency in performing procedures appropriate for an internist. At this institution, this documentation takes the form of a paperless Web-based electronic procedure data-base that is part of our *MyEvaluations.com* system, also used for all of our form-based clinical evaluations and work hours tracking. Credit is granted both for performing procedures and for primary supervision of procedures, once competency has been established. First year residents performing procedures need an appropriately credentialed supervising resident or attending physician to electronically confirm the procedure. Residents credentialed to independently perform or supervise a procedure require an attending physician's electronic confirmation that the procedure was performed for inclusion in that resident's electronic procedure log.

- (d) The American Board of Internal Medicine requires that candidates for certification meet high standards of humanistic behavior in their professional lives. The essential human qualities required of candidates seeking ABIM certification are INTEGRITY, RESPECT and COMPASSION. It is a major responsibility of the resident training program to stress the importance of humanistic qualities in the relationship between patient and physician and to assess these qualities in its residents.

17. GRIEVANCE PROCEDURE:

- (a) The term "grievance" is defined as a dispute or controversy arising in the interpretation or application of this contract or any rule or regulation or policy or practice of the Health Center which pertains to the residency program.
- (b) In the event that the HOUSE OFFICER has a grievance as defined herein above, he/she may within fourteen (14) days make a request in writing to the Internal Medicine Residency Program Director for a hearing before the Program Director and the Vice President of Medical Affairs (VPMA)/ Designated Institutional Officer (DIO). A hearing shall be scheduled with a reasonable time after such request is received by the Program Director.
- (c) Within one week after the conclusion of the hearing, the VPMA/DIO shall Report the findings and recommendations of the hearing to the HOUSE OFFICER involved.
- (d) Within fourteen (14) days after receipt of the findings and recommendations of the hearing, the HOUSE OFFICER may appeal the decision to an Appeals Committee approved by the VPMA/DIO that can include a member of the core teaching faculty and/or a resident requested by the HOUSE OFFICER involved. The decision of the Appeals Committee shall be final.

18. SICK LEAVE, FAMILY LEAVE, LEAVES OF ABSCENCE:

- (a) Please note that the ACGME and ABIM require that any significant time lost due to illness or pregnancy (exceeding four weeks over the thirty-six month training period) or personal leave requires extension of the residency training period to make up for the time lost. Vacation leave is essential, per ABIM, and cannot be forfeited to compensate for any reason.
- (b) Short leaves for documented illness of 1 week or less can generally be accommodated by the Program. Illness of greater than 1 week duration or illness resulting in frequent absenteeism requires activation of short term or long term disability per our HR policy. There are NO specified or guaranteed number of “sick days” that can be accrued and used as vacation.
- (c) Family Leave for Pregnancy or Illness or to care for a spouse or child as a primary caregiver is allowed per the Family Medical Leave Act of 1993. Up to 4 weeks of paid and up to 8 additional weeks of unpaid Maternal Leave is allowed. One week of paid and up to 3 weeks of unpaid Paternal Leave is allowed, unless the father must care for his wife as a primary caregiver, in which up to 4 weeks of paid and 8 weeks of unpaid Family Leave is allowed. As stated above, any time on Leave that exceeds one month during the 36 months of residency training must be made up to qualify for ABIM certification.
- (e) Personal leaves of absence without pay for reasons other than illness or pregnancy are granted by the Program Director based on individual circumstances.

19. POLICY ON PHYSICIAN IMPAIRMENT AND SUBSTANCE ABUSE

- (a) See Appendix B: SSM St. Mary’s Health Center Practitioners and Providers Aid Policy.

20. POLICY ON SEXUAL HARASSMENT

- (a) See Appendix C: SSM St. Mary’s Health Center Harassment Policy.

APPENDIX A

How to Count Vacation Days:

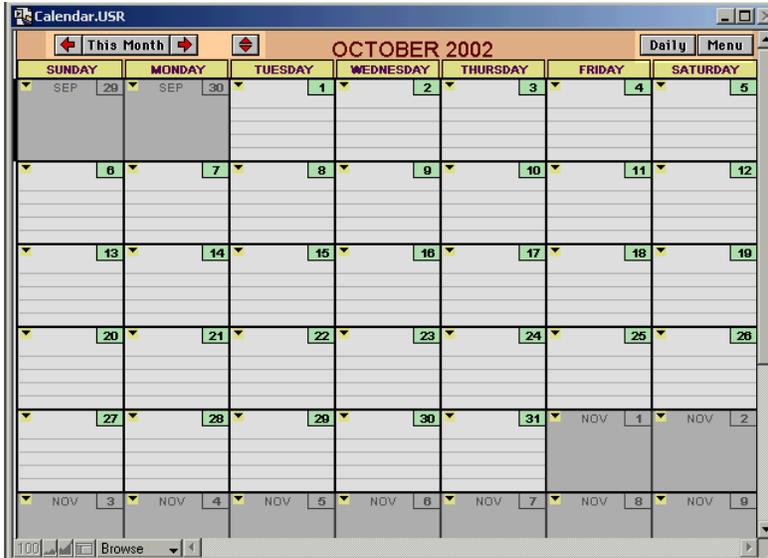
1) The paid vacation days number **21** to allow 3 weeks off with pay. These are days during which you are totally free of **any** work responsibilities of any type--whether scheduled, call, jeopardy, etc. If we ask you to be available in any way, then the day is not counted as vacation. By the same token, if you ask to be totally free of **any** responsibility to the Program, then those days must be taken and counted as vacation days.

Weekends and holidays are different from vacation, as everyone is potentially at risk of some responsibility, though subsequent adjustment must be made to maintain adherence to RRC Rules. Also, please note, that if all weekends were truly off and like a vacation, and we only counted weekdays as workdays, then your contract would specify 15 days of paid vacation (5 weekdays per week X 3 = 15 days) plus the associated weekends. This concept is very important to the rules that follow.

2) Please refer to the October Calendar reproduced below when following the examples given.

Vacations will include the entire period you are off duty without **any** responsibility to the Program. **If you ask to be excused from any call or jeopardy on a weekend that precedes or follows weekdays that you are on vacation, those weekend days must be counted as vacation** just as the weekend days in the middle of a two week vacation must be counted. You cannot schedule a vacation from Oct. 7 through Oct. 11, ask to be scheduled "off" the weekends of Oct. 5,6,12, and 13 and only count 5 days of paid vacation. This, if done 4 times, as has been done many times the past 2 years, results in a total of 36 paid days off with 1 day off still available for a total of 37 paid days off on vacation. This creates many problems both in fairness among housestaff, and in scheduling call, jeopardy, weekend coverage, and mandated days off.

A vacation extending from Oct. 5 thru Oct 11 counts as 9 days of vacation. A vacation extending from Oct. 5 thru Oct 20 counts as 16 days. If you ask for vacation from Oct. 7 thru Oct. 13, this counts as 7 days. If you are not scheduled to work the weekend of Oct. 5 and 6 preceding your requested vacation, we still expect you to be available in town in case of an emergency or to take your clinic patient calls, etc. Attempts at gaming the system simply shifts responsibility and work to those who do not game the system and will result in the additional days counted and potential adverse action.



3) As all of you know, we have always gone to great lengths to accommodate your needs for weekends off for family events, weddings, fellowship interview days, etc. without counting these as vacation days. We have, I believe, been extraordinarily accommodating in scheduling out of town electives to enhance fellowship or job opportunities, in spite of their "cost" to the program in lost federal funding. Inappropriate "stretching" of vacations, without adhering to the rules in number 2 above, place this all in jeopardy.

4) There are no contractually guaranteed "sick days", despite myths to the contrary. As all of you know, the Program has always been very accommodating regarding real illness or even illness of family members. Housestaff gaming "sick" days by feigning illness would force strict adherence to "SMHC employee" guidelines and eliminate our ability to accommodate housestaff in real need of special help.

5) Note: You are highly encouraged to schedule your vacations during the first or last week of your elective month to ensure continuity of education. The above dates are merely examples of vacation planning.

6) Residents who leave town or leave the country on vacation **MUST** schedule their travel/flights in such a way as to be certain they will be back on duty as scheduled. Given the current state of air travel, planning a return on the day before duty appears to be insufficient to avoid almost predictable delays of up to 24hrs. The only Program acceptable delays are "acts of god" that are very unusual or unpredictable e.g. volcanic ash or airline strikes. Weather delays of up to 24 hrs, canceled flights, overbooked flights are not acceptable excuses. If a resident returns late, the jeopardy resident will be called in. Payback from the late-arriving resident to the jeopardy resident for "act of god" delays will be one to one; all other **delays will be paid back at a ratio of 5 days for each day worked.**

APPENDIX B

SSM ST. MARY'S HEALTH CENTER IMPAIRED PHYSICIAN POLICY AND PROCEDURE (PRACTITIONERS' AND PROVIDERS' AID POLICY)

PURPOSE

The purpose of the Practitioners' and Providers' Aid Policy ("Policy") of the SSM St. Mary's Health Center/Cardinal Glennon Children's Hospital ("Hospital") Medical Staff is designed to promote the well-being and health of Practitioners and Providers practicing at the Hospital, while at the same time ensuring safe patient care. This Policy is designed to provide a framework for identifying, intervening, promoting rehabilitation and monitoring Practitioners and Providers who are identified as impaired. The Policy will be primarily implemented by the Practitioners' and Providers' Aid Committee ("Committee") as set forth herein. All definitions used in this Policy shall have the same meaning as the defined terms in the Medical Staff Bylaws.

STATEMENT OF PHILOSOPHY

SSM St. Mary's Health Center/SSM Cardinal Glennon Children's Hospital recognizes alcoholism, substance abuse, psychiatric illness and behavioral impairments as illnesses and believes that Practitioners and Providers are susceptible to these illnesses, which may affect their ability to function at optimal levels. Because these impairments can be successfully treated, the Medical Staff's policy is to treat any Practitioner or Provider who suffers from these illnesses in the same manner as Practitioners and Providers who have other illnesses.

DEFINITIONS

1. *Impaired Physician:* An impaired Practitioner or Provider is one whose behavior has been affected by alcohol, chemicals, mental illness, or any other illness which interferes with the Practitioner or Provider's individual health, economics or ability to function competently. This behavior is often characterized by compulsion, loss of control and, in cases involving Drugs or Chemicals, continued use of Drugs and Chemicals despite adverse consequences. A Practitioner or Provider may be impaired in his/her ability to perform professional responsibilities, function responsibly in financial matters, or behave in a sexually responsible manner (i.e., sexual inappropriateness with patients, sexual addiction or sexual harassment).
2. *Drug or Chemical*
 - a) any over the counter medication
 - b) any prescribed medication
 - c) any illegal or unprescribed chemical substance
 - d) any alcoholic beverage
 - e) any substance causing adverse psychological behavior

APPENDIX B (cont'd)

3. *Drug or Chemical Related Misconduct:* Drug or Chemical Related Misconduct includes, but is not limited to, possession and/or illegal distribution of Drugs or Chemicals on either the SSM St. Mary's Health Center campus or the SSM Cardinal Glennon Children's Hospital campus; use of the Drugs or Chemicals on either campus; use of Drugs or Chemicals off-campus that adversely affects the Practitioner or Provider's performance, his/her own safety or others' safety at work, or negatively reflects on the reputation in the community of SSM St. Mary's Health Center, SSM Cardinal Glennon Children's Hospital, or any SSM Health Care-affiliated organization.
4. *Missouri Physician's Health Program (MPH Program):* The MPH Program is the Missouri impaired physicians' program, sponsored by the Missouri State Medical Association. (See, Appendix A-MPH Brochure).
5. *Intervention:* An intervention is an organized confrontation between a group of concerned, trained individuals and a potentially impaired Practitioner or Provider for the purpose of motivating that Practitioner or Provider to accept evaluation and treatment for his/her impairment. The intervention will include the Committee Chairperson, the campus-specific Medical Staff President or his/her designee, a representative of the MPH Program for physicians or other appropriate professional treatment provider, and depending on the circumstances, a spouse, practice partner, office staff, close friend, etc.
6. *Evaluation:* An evaluation is an assessment of the impaired Practitioner or Provider by a professional treatment provider and/or treatment center outside of SSM St. Mary's Health Center or SSM Cardinal Glennon Children's Hospital.
7. *Treatment:* Treatment is the process whereby the Practitioner or Provider is assisted to recognize and change behavior patterns contributing to the impairment. Treatment may range from individual psychotherapy to inpatient hospitalization.
8. *Monitoring:* Monitoring of an impaired Practitioner or Provider will be done by the MPH Program or other appropriate professional treatment provider. Regular reports as to the Practitioner or Provider's compliance and progress in recovery will be communicated to the campus-specific Medical Staff President and the campus-specific Hospital President or their respective designees, and the Committee.
9. *Advocacy/Care and Treatment Agreement:* Each Practitioner and Provider who is subject to an intervention and who is deemed to require evaluation and treatment will be required to enter into an appropriate Care and Treatment Agreement with the Hospital consistent with SSM Health Care policy. In addition, physicians participating in the MPH Program shall also

APPENDIX B (cont'd)

be required to enter into the MPH Program's Advocacy Agreement. (*see Appendix B-MPH Advocacy Agreement*).

ADMINISTRATIVE PROCEDURE

1. In the event any Practitioner or Provider or Health Center employee has information regarding a potentially impaired Practitioner or Provider, a report shall be made to the Committee.
2. An investigation will be conducted by the Committee to determine the validity of the report. If the investigation reveals there is a reasonable belief that Practitioner's or Provider's practice or performance is impaired, immediate steps will be taken to protect patients.

Careful, complete documentation of all steps taken will be maintained by the Committee. All records shall be kept in a designated locked place in the campus-specific Medical Staff Services Office. Only the Committee, the campus-specific Executive Committee, the Medical Executive Committee and the Board may have access to this information. These records will not be stored with a Practitioner's or Provider's credentials file or personnel file, if a personnel file exists.

3. In the event the Committee determines there is a reasonable belief that a Practitioner or Provider is impaired, an intervention will be coordinated with all persons deemed necessary for the intervention, as determined by the Committee Chairperson. A request will be made that the Practitioner or Provider voluntarily submit to an evaluation and follow any recommendations made by the treating professional and treatment facility. The Practitioner or Provider will be given a choice of treatment locations but must obtain an evaluation by an individual professional or treatment facility approved by the Committee.

The impaired Practitioner or Provider shall be responsible for all treatment costs not covered by health insurance, as well as the fees for monitoring and follow-up.

4. If a Practitioner or Provider follows this course of action following an intervention, no suspension of clinical privileges or any other disciplinary action shall be taken by the Medical Staff. However, if the Practitioner or Provider continues to practice during his/her treatment, and an independent concern arises with respect to the Practitioner's or Provider's ability to safely provide patient care, nothing will prevent the initiation of an investigation or appropriate corrective action to address the patient care concern.

In the event a Practitioner or Provider refuses to submit to an evaluation, and there is a reasonable belief that the Practitioner or Provider may represent a danger to the health or safety himself/herself, any patient, or any member of the Hospital's workforce, the affected Practitioner or Provider may be suspended from the Hospital's Medical Staff or Allied Health Professional Staff, as applicable.

APPENDIX B (cont'd)

5. Long term follow-up of Practitioners and Providers who require evaluation and treatment will be provided by the MPH Program in accordance with the MPH Advocacy Agreement and/or another professional treatment provider through a Care and Treatment Agreement with the Hospital, as applicable. The impaired Practitioner or Provider will agree to sign any release forms allowing the MPH Program, individual treatment provider or other treatment program to report to the campus-specific Medical Staff President, the campus-specific Hospital President, the Committee and any other monitor agreed to by the Practitioner or Provider, to evaluate compliance with the terms of the treatment program, document successful completion of the treatment program, and/or compliance with ongoing monitoring requirements.
6. In the event the Committee at any time during the procedure outlined herein believes that the Practitioner or Provider is not complying with the required treatment plan or refuses to follow the recommendations of the individual treatment provider or treatment program, the campus-specific Executive Committee will consider recommending or taking appropriate corrective action, which may include any appropriate action, up to and including termination of the Practitioner's or Provider's ability to practice at the Hospital.
7. The impaired Practitioner or Provider must receive a release to return to work from the individual treatment provider or treatment program before returning to practice at the Hospital.

CONFIDENTIALITY

If a Practitioner or Provider agrees to all of the recommendations set forth in this Policy, at no time will any information concerning the impairment be disclosed to anyone other than the campus-specific Medical Staff President, the Committee, the campus-specific Executive Committee, the Medical Executive Committee, the Board, any individual treatment provider or treatment program, any other individual specifically authorized by Practitioner or Provider to receive such information, and, if applicable, those persons involved in the intervention process.

Approved by St. Mary's/Cardinal Glennon Medical Executive Committee -

05/07/03

Approved by SSM Health Care St. Louis/Cardinal Glennon Board of Directors -

05/19/03

APPENDIX C

SSM ST. MARY'S HEALTH CENTER

MEDICAL STAFF POLICY & PROCEDURE HARASSMENT

The SSM St. Mary's Health Center/SSM Cardinal (Glennon Children's Medical Staff expects that all Practitioners and Providers will behave at all times in a manner that contributes to enhancing the dignity of each person and refrain from engaging in any form of harassment based on race, color, sex, religion, national origin, age, disability, or any other category protected by law (see Definition) towards employees, patients, visitors, and other Practitioners and Providers. All definitions used in this Policy shall have the same meaning as the defined terms in the Medical Staff Bylaws.

PROCEDURE

The Director of Human Resources and/or Risk Manager will immediately forward any allegations of harassment against a Practitioner or Provider to the President of the Medical Staff who will work closely with Human Resources in promptly and thoroughly investigating all allegations of harassment in conjunction with Article 7: Investigation and Corrective Action Policy set forth in the Credentials and Hearing and Appellate Review Policy and Procedure Manual.

DEFINITION

Harassment includes unwelcome conduct, whether verbal, physical or visual, which creates an intimidating, offensive, or hostile work environment or that unreasonably interferes with job performance. Harassment includes unwelcome and offensive slurs, jokes, or other similar conduct.

Sexual harassment deserves special mention. Sexual harassment is defined as, but not limited to, unwelcome sexual advances, requests for sexual favors and other verbal, visual or physical conduct of a sexual nature. Sexual harassment includes unwelcome sexual flirtations, advances, propositions, verbal abuse of a sexual nature, subtle pressure or requests for sexual activities, sexually degrading words used to describe an individual, sexual innuendo, suggestive comments, sexually oriented kidding, teasing, or practical jokes, displays in the workplace of sexually suggestive objects, pictures, or printed material, sexually orientated jokes, unconsented contact with another individual's body or any other activity which creates a hostile work environment based upon sex.

Approved by St. Mary's/Cardinal Glennon Medical Executive Committee -

05/07/03

Approved by SSM Health Care St. Louis/Cardinal Glennon Board of Directors -

05/19/03

APPENDIX D

SMHC Policy on Internal Medicine Resident On-Call Coverage For the Uncovered (Non-Teaching) Services

On Call Coverage Policy:

Covered Medical Service: The On-Call residents are responsible for **ALL** physician-appropriate calls, including routine, sub-acute, and acute/emergency.

Uncovered Service: Medical Residents are **NOT** responsible for and should not be called for patients who are uncovered. The On-Call PGY2 or PGY3 resident, according to recently defined RRC requirements, may only care for a non-teaching patient who has a hyper-acute life threatening medical emergency—the original intent is too allow for cardiac or respiratory resuscitation, though events imminently predictive of arrest certainly qualify.

The new availability of the Nursing Service-based Emergency Response Team (ERT) provides coverage for most potentially serious emergent patient needs on the uncovered service and the ERT can appropriately call the On-call Resident if they identify an emergent life-threatening problem.

PGY1 residents have no responsibility for uncovered patients but may participate in cardiac resuscitation (i.e., Code Blue) on uncovered patients under supervision of a PGY2 or PGY3 resident.

To summarize with examples:

On the **Uncovered** Service PGY2 or PGY3 Medical Residents CAN be called for:

- Cardiac and Respiratory Arrests ('Codes')
- Impending-Arrest instability (ERT usually called first)
- ERT determines Resident is needed

On the **Uncovered** Service Medical Residents CANNOT be called for:

- medications, fluids
- x-ray review
- anxiety, delirium/confusion
- falls, lacerations
- non-life-threatening chest pain, SOB, desaturation, and decline in mental status.

On the Uncovered Service, responding to calls about these clinical scenarios remains the responsibility of the attending physician.

Relevant Definitions:

Internal Medicine Resident: A medical school graduate in possession of a hospital-sponsored temporary medical license who is a post-graduate student enrolled in an educational program that is accredited by the ACGME and the ABIM to train and prepare post-graduate physicians to be Internal Medicine Specialists, sit for the certification examination given by the ABIM and to be independently licensed physicians. The training is 36 months in duration divided into 3 one year blocks: PGY1 (Intern), PGY2 (junior supervising resident) and PGY3 (senior supervising resident.)

ACGME (Accreditation Council for Graduate Medical Education): A private, not-for-profit accrediting organization (very similar to the JCAHO) that is responsible for overseeing and establishing standards for residency training, including in recent years, very specific requirements defining precisely the content and structure of the training and the environment in which training can occur (e.g., recently in the press, the 80 hour work week limit). An Internal Medicine Residency Review Committee (**RRC**) defines the “Essentials of an Accredited Residency” which consists of over 600 specific requirements that are either “musts” (absolute requirements that cannot be modified and jeopardize accreditation) or “shoulds” (required but can be modified depending on institutional characteristics.) *The requirements regarding emergency on-call activity fall into the “must category” and have been recently redefined and made more stringent. The current guiding principle of the Internal medicine RRC is that ALL resident program activity must have definite educational benefit to the trainee and must be part of the structured educational curriculum i.e., there should be NO principally service activity.*

ABIM (American Board of Internal medicine): The Internal Medicine professional board that defines the requirements for Certification as an Internal Medicine Specialist (i.e., a Board-Certified Internist.). The basic requirement is completion of a 3-year residency accredited by the ACGME and the ABIM and successful performance on a national certification examination (the “Board Exam” or “Boards”).

Covered Medical Service: The Residency Teaching Service comprised of patients admitted under an Internal Medicine Attending Medical-Staff Physician but for whom Housestaff have shared-primary responsibility from admission to discharge based on the Attending Physician and patient’s agreement to participate in the resident’s education, under close supervision of the Attending and the Program Faculty.

Revised 04/2014

Un-Covered Service: All patients not on the Covered Service.

Questions regarding this Coverage Policy, that is the result of changes in RRC requirements, should be directed to:

Morey Gardner, M.D.

Program Director
Internal Medicine Residency
314 768-8778
morey_gardner_md@ssmhc.com

APPENDIX E

Rotation: Internal Medicine Inpatient Floors

Overview:

Patients of varying age, ethnic background, and economic status with a wide diversity of diseases are managed on the general medicine services. Admissions to these services are arranged from private offices and SMHC outpatient clinics the Emergency Room or are transferred from an outside institution or from one of our intensive care units. Learning on this service is patient-based and requires extensive reading on the diseases encountered. The outlined educational competencies should be achieved by completion of the training program.

The overall goal of our general medicine inpatient rotations is the achievement of a level of performance in all competencies which is predictive of success in independent practice as an internist and is predictive of success on the ABIM certifying examination.

Goals by Level of Training:

PGY1

1. To perfect data acquisition skills including history taking with the patient and the family and review of the past medical records and demonstrating the understanding of the importance of primary information, physical examination, pertinent laboratory studies for inpatients, and cost-effective ancillary studies.
2. To develop a knowledge base required to systematically approach the management of patients hospitalized for acute and chronic medical conditions demonstrating competence in the immediate care of the unstable patient, diagnosis and problem definition, selection and prioritizing of appropriate diagnostic studies, discharge planning including education of the patient's family and/or preparation for rehabilitative care or other long-term care placement.
3. To assume the role of critical central caregiver under careful supervision of supervising residents and faculty, and as such, RIs will be expected to maintain excellent communication with patient's families members and other members of the healthcare team including students in order to optimize the care that is provided.
4. To be able to understand, explain and employ the use of intravenous fluids, antibiotics, and other pharmacologic and therapeutic agents in patient care.

PGY2

1. To provide leadership in creating an environment that emphasizes quality evidence-based patient care.
2. To directly supervise and educate interns and medical students in the delivery of high quality inpatient medical care.
3. To develop and teach an understanding of continuity of care from the inpatient to outpatient setting in the management of chronic diseases.
4. To recognize the importance of nutrition in serious illnesses, human values and ethics as they apply to advance directives, death and dying, and the unique aspects of geriatric medicine in the hospital.
5. To refine the knowledge of diseases requiring hospital management and to share this knowledge base with interns and medical students.
6. To comprehend and apply medical economics, i.e., charges, coding, cost effectiveness and cost containment, as it relates to in-patient care.
7. To understand, practice, and teach the prevention of hospital-associated (nosocomial) infections and other health-care associated complications in the acute care setting.
8. To collaborate with nurse practitioners, physician extenders, and case managers; to use consultants appropriately during hospitalization; and to coordinate care with consultants.

PGY3

1. Demonstrate leadership within the resident teams and within the residency program in creating an environment that emphasizes quality, safety, and the highest standards of evidence-based patient care.
2. Supervise and educate interns, medical students, nurses and other healthcare professionals in the delivery of high quality inpatient medical care.
3. Demonstrate a sophisticated understanding of transitions of care from the inpatient to outpatient setting in the management of chronic diseases.
4. Demonstrate an understanding of the importance of nutrition in serious illnesses, human values and ethics as they apply to advance directives, death and dying, and the unique aspects of geriatric medicine in the hospital.
5. Demonstrate a sophisticated knowledge of diseases requiring hospital management and share this knowledge base with interns and medical students.
6. Demonstrate an understanding of medical economics, i.e., charges, coding, cost effectiveness and cost containment, as it relates to in-patient care.
7. Demonstrate a commitment to the prevention of hospital-associated (nosocomial) infections and other health-care associated complications in the acute care setting.
8. Collaborate in a sophisticated manner with nurse practitioners, physician extenders, and case managers; use consultants appropriately during hospitalization; and coordinate care with consultants.

Objectives at all Levels of Training:

Patient Care:

Obtain an appropriate history and perform physical examination to enable the detection of medical illnesses, including the following:

- DVT/thromboembolism
- diabetes mellitus out of control and diabetic ketoacidosis
- community-acquired pneumonia, aspiration pneumonia, and institutionally-acquired pneumonia
- acute and chronic renal failure
- cellulitis/erysipelas/osteomyelitis/diabetic foot ulcers
- asthma and COPD exacerbations
- urinary tract infections, pyelonephritis, and urinary tract infections with sepsis
- hypertensive urgency and emergencies, formerly called malignant hypertension
- endocarditis
- meningitis, encephalitis
- coronary artery disease
- the use of non-invasive testing and consultants
- new onset atrial fibrillation
- anasarca/CHF/ascites/nephrotic syndrome
- anemia
- hypothyroidism and hyperthyroidism
- acid-based disorders, hyponatremia, hypernatremia, hypokalemia, hyperkalemia
- decubiti
- acute monarticular arthritis
- obstipation/bowel obstruction
- CVA
- depression
- alcohol withdrawal syndrome
- diverticulitis
- exacerbations of systemic lupus erythematosus
 - seizure
- sickle cell anemia disorders

Medical Knowledge:

Apply current best evidence to patient care and risk factors for the following hospital-acquired conditions:

- hospital-associated urinary tract infections
- hospital-associated pneumonia including aspiration pneumonia

- decubitus ulcer formation
- ileus/obstipation
- acute renal failure
- CHF
- mental status changes
- DVT

Identify the most common causes of the following symptoms in hospitalized patients:

- chest pain
- dyspnea
- headache
- mental status changes including delirium and stupor/coma
- acute abdominal pain
- new fever
- new rash
- lower extremity edema
- anorexia, constipation, diarrhea, nausea/emesis
- hematochezia
- cough
- dizziness
- swollen joint
- weakness
- syncope

Practice-Based Learning and Improvement:

1. Develop a willingness and ability to learn from errors and use them to improve the health care system
2. Utilize information technology resources to support patient care decisions
3. Use information technology to enhance patient education

Interpersonal and Communication Skills:

1. Demonstrate effective negotiation and mediation skills with:
 - narcotic-seeking patients
 - angry/frustrated patients and/or their families
 - family members in disagreement on appropriate care of loved one
2. Demonstrate effective communication and mediation skills regarding family-physician disagreements about end-of-life decision making
3. Demonstrate compassionate, patient-centered interviewing techniques in patients with chronic and recurrent illnesses; patients who are elderly and slow; patients who are angry/frustrated; patients who are poorly educated
4. Complete discharge dictations in a timely manner

Professionalism:

1. Seeks methods to enhance effective communication and understanding with patients of different cultural/ethnic backgrounds
2. Avoid judgmental behavior in patients with chronic pain syndromes and demonstrate effective communication skills to plan appropriate pain treatment regimens in collaboration with the patient
3. Describe and apply appropriate indications for “comfort care” status as well as “DNR” code status
4. Provide meaningful feedback to colleagues regarding his/her performance

Systems Based Practice:

1. Recognize the importance and added value of contact with the patient’s primary care physician upon patient admission to the hospital
2. Recognize the added value of direct communication with other health care professionals (nurses, physical therapists, dieticians) when specific orders are desired

3. Interact with social workers and practice management on a daily basis for effective patient discharge planning
4. Understand the value of accurate, appropriate documentation in achieving expectations with regard to clinical quality core-measures and appropriate imbursement.

Learning Venues:

Patient Characteristics:

1. The medicine ward rotations take place at St. Mary's Health Center. Patients on the ward services are highly diverse socioeconomically and have a full spectrum of disease processes.

Organization of Inpatient Service and Structure of Supervision:

1. Each ward team (A, B and C) is headed by a single teaching attending physician who is responsible for teaching on all patients on the service. On Teams A and C, the teaching attending physician is a core faculty member who is also the physician of record for all patients on these teams. On Team B, the teaching attending is the physician of record for all clinic patients on the team. The physicians of record for the other patients on Team B are private faculty or one of the academic hospitalists. Clinical supervision is the responsibility of the Physician of Record, whether the physician is Private Faculty or Full-Time Core faculty.

Teaching Methods:

1. Residents are expected to read articles, references, and texts regarding their patients' problems at both point-of-care and post care.
2. Residents are expected to participate in all daily teaching rounds, conferences, and teaching-associated experiences and activities.
3. Residents are expected to teach medical students, nurses, pharmacists, patients, fellow residents and attending physicians as is appropriate.

Evaluation:

1. All residents are evaluated on the above core competencies each month through an attending evaluation sent electronically through *MyEvaluations.com*. Mid-month interim feedback is encouraged.
2. MS4s are evaluated per SLU specified procedures.
3. MS3s are evaluated per SLU specified procedures

Resources:

Library-based Harrison's and Cecil's and other textbooks of medicine
Web-based ACP Medicine textbook (formerly Scientific American Medicine)
Web-based "Up-to-Date"
Web-based "MD Consult"
Intranet based "SMHC Internal Medicine Clinical Handbook"

Competency Evaluation:

Every month each resident will be evaluated by their faculty preceptors via the electronic evaluation *MyEvaluations.com*. Every six months they will be assessed by nursing staff, patients, and their peers using standardized web-based assessment tools, direct observation, written questionnaires, and record review checklists. The break down by competency is as follows:

1. Patient care
 - Web-based faculty global assessment
 - CEX or Mini CEX
 - Patient record
2. Medical knowledge
 - Cex or Mini Cex
 - Web-based faculty global assessment
 - Once Yearly ACP-ASIM in-training examination

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- Subspecialty “Selective” end-of rotation shelf exams.
- 3. Practice-based learning and improvement
 - Web-based faculty and Peer global assessment
 - Patient record review
 - Monthly Power-Point clinical conference presentations, monthly M & M conferences, and monthly Death Review conferences.
- 4. Interpersonal skills and communication
 - Web-based faculty global assessment
 - 360-degree evaluations
- 5. Professionalism
 - Web-based faculty global assessment
 - 360-degree evaluations
- 6. Systems-based practice
 - Web-based faculty global assessment
 - 360-degree evaluations

Outcomes Assessment:

1. ACP-ASIM Internal Medicine In-training Examination - goal is for each houseofficer to score 40th percentile or better. (predictive of passing ABIM examination)
2. American Board of Internal Medicine Board Passage Rate - goal is for the annual program pass rate to be 100%.

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