LOYOLA UNIVERSITY MEDICAL CENTER
DEPARTMENT OF INTERNAL MEDICINE

Internal Medicine Residency Handbook
Department of Medicine
Loyola University Medical Center
Maywood, IL
2018-2019
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*Updated 6/5/2018*
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Introduction

Welcome to Loyola University Medical Center and the Department of Medicine! This IM Residency handbook has been updated for the current academic year to provide all residents and interns with the necessary information to allow them to function effectively in our Residency Program. We have made an effort to make this document succinct, and yet inclusive of important policies and programs that you will encounter during your training experience. If there is additional information you believe would be helpful to include in this document please email your suggestions to the Chief Residents to be considered for inclusion in next year’s handbook. Any updates or changes to existing policies/programs that occur during the year will be incorporated into this document and uploaded on the Loyola Internal Medicine Homepage, as well as communicated via email as appropriate.

In addition to a reference for specific policies we hope that this handbook will also help to define the roles and responsibilities of each member of the medical team. While it is not possible to be precise in each individual’s role in each clinical scenario, this handbook will provide a general framework around which the organization of the medical team should be structured. By clearly defining roles and expectations for each team member we hope to facilitate a strong learning environment for individuals at various levels of training and to create a functional and efficient team unit.

We hope you find this to be a very useful resource throughout your training. Please direct any questions to the Chief Residents, Associate Program Directors, and/or Program Director. In all circumstances if you are unclear on what is expected of you we encourage you to act professionally, to put patient’s needs first and foremost, and to ask for help or clarification when it is needed.

Additional information can always be found on our residency’s web page:
www.loyolamedicine.org/gme/internal-medicine-residency
Residency Leadership

**Loyola**

**Dr. Ravi Durvasula** – Chair of the Department of Medicine  
**Dr. Kevin Simpson** – Program Director, Internal Medicine Residency Program  
**Dr. Nate Derhammer** – Program Director, Combined Internal Medicine/Pediatrics Residency Program

**Hines**

**Dr. Ivan Pacold** – Chief of Medicine, Hines VA Hospital

**Associate Program Directors (APDs)**

**Dr. Amit Dayal** – Hines VA Hospital  
**Dr. Bryan Gee** – Hines VA Hospital  
**Dr. Bruce Guay** – Hines VA Hospital  
**Dr. Meghan O’Halloran** – Hines VA Hospital  
**Dr. Melissa Briones** – Loyola University Medical Center  
**Dr. Nate Derhammer** – Loyola University Medical Center  
**Dr. Laura Ozark** – Loyola University Medical Center  
**Dr. Ellen Parker** – Med/Peds at Loyola University Medical Center  
**Dr. Dan Sisbarro** – Loyola University Medical Center

**Chief Residents (CRs)**

**Dr. Vivian Irizarry Gatell** – Loyola Inpatient  
**Dr. Bill Meyer** – Hines Inpatient  
**Dr. Katarzyna (Kasia) Kadela** – Ambulatory  
**Dr. Matthew Laubham** – Research  
**Dr. Tony Kurian** – Quality and Safety Chief Resident at Hines VA
Resident Support Staff

LOYOLA

Steve White – Program Coordinator for the Internal Medicine residency program. His office is in Room 7603, phone extension x65522, and email spwhite@lumc.edu. Most questions can be answered via email. Steve is in charge of our intern recruitment program and onboarding of all new interns. He will assist you with Step 3 registration, licensing, board registration, and ACLS/BLS training registration. Steve also manages ACP memberships, MKSAP, and ITE examinations.

Jill Wallock – Program Coordinator for the Internal Medicine/Combined Medicine-Pediatrics residency programs. Her office is in Room 7613, phone extension x66053. Jill is our New Innovations (evaluation system) guru. She is in charge of rotational evaluations and weekly switch documents. She can assist you with your red meal card. Jill keeps track of the advising program and maintains admission and procedural logs.

Please feel free to ask either Steve or Jill any residency related administrative questions.

Michelle Armstrong – Program Coordinator for the Neurology residency program. For our PGY1 clinical base year neurology residents, while Jill and Steve will act as your coordinators during your first year in many regards, Michelle will assist with some neurology program issues that carry on throughout the duration of the neurology residency program.

HINES VA

LaWanda Rucker – Ms. Rucker is the computer support contact for Hines VA. She can assist you with most computer issues as well as obtaining home access. Her phone number is 708/202-8387 x24564 and pager is 708/718-1753. Her office is on the 14th floor of the main VA hospital building 200, room 1479.
## Roster of Interns and Residents 2018-2019

### Categorical PGY 1 (31)

<table>
<thead>
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<th>Categorical PGY 1 (31)</th>
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<tbody>
<tr>
<td>Kent Aje</td>
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<tr>
<td>Nathalie Antonios</td>
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<tr>
<td>Piotr Babinski</td>
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<tr>
<td>Arouj Bajwa</td>
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<td>Stephanie Betcher</td>
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<td>Brian Birks</td>
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<tr>
<td>Cody Braun</td>
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<td>Nicholas Brement</td>
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### Preliminary PGY 1 (11)

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<tr>
<td>Gianna DiGrazia</td>
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<td>Daniel Guay</td>
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<td>Magdalena Harasimowicz</td>
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### PGY 2 (33)

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<td>William Aitken</td>
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<td>Michael Belmont</td>
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<td>Lucas Chan</td>
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<td>Laya Charara</td>
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<td>Angelo Ciliberti</td>
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<tr>
<td>Tyler Cunningham</td>
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<tr>
<td>Travis Desa</td>
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<td>Navkiran Dhillon</td>
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### PGY 3 (32)

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<td>Jamie Chin- Theodorou</td>
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<td>Daniel Colon Hidalgo</td>
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<td>Jessy Dabit</td>
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<td>Matthew Decker</td>
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### MEDICINE/PEDIATRICS

#### PGY 1

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<tbody>
<tr>
<td>Zahra Ismail</td>
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<td>Gabriela Lobato</td>
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<td>Kyle Walding</td>
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<td>Shannon Michel Wynn</td>
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#### PGY 2

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<td>Emily Kahn</td>
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<tr>
<td>Mickey Kuo</td>
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<tr>
<td>Suzanne Ngo</td>
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<td>LaBianca Wright</td>
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#### PGY 4

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<tbody>
<tr>
<td>Adam Van Huis</td>
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<td>Anam Syed</td>
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Housestaff Photos

Chief Residents 2018-2019:

Dr. Vivian Irizarry-Gattell
Loyola Inpatient

Dr. Bill Meyer
Hines Inpatient

Dr. Tony Kurian
Quality and Safety

Dr. Kasia Kadela
Ambulatory

Dr. Matt Laubham
Research

Categorical Residents:

Categorical PGY1 Interns:

Kent Aje

Nathalie Antonios

Piotr Babinski

Arouj Bajwa

Stephanie Betcher

Brian Birks

Cody Braun

Nicholas Brement

Randall Cabrera
Preliminary PGY1 Interns:

Gianna DiGrazia  
Daniel Guay  
Magdalena Harasimowicz

Ryan Hutten  
Kyle Malecki  
Monique Montenegro

Joseph Ness  
Dhruvesh Patel  
Aman Prasad

Yuxiao Qian  
Nicholas Szrama
PGY2 Residents:

William Aitken

Rehmat Ullah Awan

Lucas Chan

Laya Charara

Angelo Ciliberti, JR

Tyler Cunningham

Navkiran Dhillon

Destry Elms

Syed Karam Gardezi

Swapna Gudipati

Jeremiah Haines

Anshu Hemrajani

Edward Kanive

Blaine Knox

Daniel Linden
Michael Belmont  
Travis DeSa  
Charles (Max) Weddington

PGY3 Residents:

Daniel Aldrich  
Brian Allen  
Colby Baker

Emily Cendrowski  
Jamie Chin  
Daniel Colon Hidalgo

Jessy Dabit  
Matthew Decker  
Swetha Gogineni

Leo Gozdecki  
Fizza Hussain  
Stephen Jumic

Christopher Kasia  
Jaclyn Keller  
Noah Landy
Clinical Base Year Neurology Interns:

Diana Andino
Carlos Lara
Laurent Loganathan
Fady Mousa-Ibrahim
Jasmine Singh
Anam Syed

Combined Medicine/Pediatrics Residents:
PGY1

Zahra Ismail
Gabriela Lobato
Shannon Michel Wynn
Kyle Walding

PGY 2

William Brundidge
Benjamin Sirbu
Maria Strus
James Trenhaile
## Firm Breakdown

<table>
<thead>
<tr>
<th>HVA AM</th>
<th>FIRM B</th>
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<tr>
<td>R1</td>
<td>Jordan Taylor; M (Meyer)</td>
<td>Andrew Go; M (Volden)</td>
<td>Simge Yukeli; F</td>
<td>Alshinna Menoni; M (Pearse)</td>
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<tr>
<td>R1</td>
<td>Kanive</td>
<td>Cody Braun; M (Sabier)</td>
<td>Sudipati</td>
<td>Yiran Gong; M (Seifther)</td>
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<tr>
<td>R1</td>
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<td>Knox</td>
<td>Qin</td>
<td>Mhidadeen</td>
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<td>Raphael</td>
<td>Keller</td>
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General Policies

The Internal Medicine residency program falls under the Graduate Medical Education (GME) department. There is useful information available on their website: http://loyolamedicine.org/gme including resident handbook (hospital-wide), licensure, benefits, and many other useful topics that are not a part of our specific departmental handbook (this document). Please take time to look through the GME webpage to familiarize yourself with many available resources that will make your time with us at Loyola even more meaningful.

In addition, you will find many order sets and protocols available on the LUMC Application Portal. To access this site while on campus, go to emr.lumc.edu and then click on the “App Portal” link at the top of the page, login with your universal logon/password, then onto the “Policies” tab at the top of the page. Scroll through the different selections and find useful protocol and procedural information.

Resident Responsibilities

General:
Each resident will be offered the opportunity to assume direct responsibility for patient care. The transfer of responsibility occurs in a graded fashion. The degree to which each resident is permitted to function "independently" depends upon individual initiative, medical knowledge, and continuously demonstrated competence. In fact, each resident's performance will be closely supervised. Below we have outlined the general roles of interns and senior residents on service teams. Please use this as a guide for the general role of each team member:

Intern responsibilities:

Primary:
- Review rotation information on website prior to starting rotation
- Receive overnight sign-out each morning
- Review appropriate EMR data and physically see each patient assigned to his/her care
- Present his/her patients on attending rounds
- Enter all orders, call all consults, and complete the daily progress note for his/her patients
- Safely and efficiently sign-out his/her patients at the end of each day
- Complete the discharge summary for his/her patients within 24 hours
- At night, be primarily responsible for patient cross cover including prompt communication with the supervising senior resident when in doubt or when patient status acutely changes
- Document any patient care provided during 'cross-cover'
- Field all service pages and be the primary contact for all nurse/ancillary staff issues
- Provide a thorough sign-out to the intern(s) taking over the service at the end of the rotation

Secondary:
- Supervise students assigned to his/her patients
- Participate in primary patient admission and procedures whenever possible
Senior responsibilities:

**Primary:**
- Review rotation information on website prior to starting rotation
- Assure appropriate care for all patients on the service including assuring that all patients have a reasonable plan established prior to attending rounds, that all orders and consult requests are completed in a timely fashion, and that all patients/families are appropriately updated
- Assign patients to the intern(s) in a fashion consistent with the intern's demonstrated level of competence
- Monitor the stress of all team members and communicate concerns to the program leadership when indicated
- Assure efficient team function to ensure punctual attendance at required conferences/WIND rounds, timely completion of daily progress notes, and compliance with all ACGME Duty Hour rules
- Share responsibility with the attending for the overall education of the team and for the timely completion of attending rounds
- Supervise intern sign-out (suggested in person at the beginning of the year)
- At night, be primarily responsible for patient admissions as well as being immediately available to the intern to oversee the safe care of all patients
- Education of intern, sub-interns and third-year medical students

**Secondary:**
- Supervise intern admissions and procedures
- Share in primary intern responsibilities as required to assure optimal patient care and housestaff well-being
- The faculty does not support the concept of the “resi-tern” (ie, a senior resident who divides up the work of the team on a regular basis). The privilege of being a senior is additional time to hone clinical skills, learn how to answer evidence-based questions, and improve leadership and teaching skills.
- The senior resident years (PGY-2 and 3) are a time for the resident to grow in their medical knowledge and problem solving. It is expected that each day, the senior should be taking some time to research current clinical information regarding current patients, and bringing that information to the team in the form of teaching. Senior residents will continually work on their leadership and teaching skills
- Provide a thorough sign-out to the senior(s) taking over the service at the end of the rotation

FAQ's:
1. While primary intern and senior responsibilities are detailed above, it is expected that interns assume primary admission and procedure responsibility whenever possible and for senior residents to assist in the completion of primary intern responsibilities whenever appropriate.
2. Specific fellow responsibilities are not addressed in the resident policy but fellows are expected to serve as an overall patient care and educational resource to the senior resident in addition to being an additional intermediary to the attending.
3. It is the responsibility of the Department of Medicine to assure all fellows/attendings are aware of this policy.
Attending Physician Notification Policy and Procedure:
Final responsibility for the patient's welfare rests on the attending physician.
Residents should notify their attending in the event that:
1. a patient is admitted
2. a patient’s condition deteriorates significantly
3. a patient is transferred to an intensive care unit
4. a patient expires
5. a patient desires to leave against medical advice (AMA)
6. a significant procedure or test is being performed (central lines, angiograms, etc)
7. the resident has any questions about the diagnostic and/or therapeutic plan

At the beginning of each month, each service attending and housestaff should discuss their preferred means of communicating during off-hours. All of the following options should be exercised in the event that there is difficulty reaching the service attending:
1. page the attending directly via the hospital paging network (usually 68777)
2. call the attending directly at home (the operators have both home and cell numbers and can call for you)
3. contact the physician answering service (66400) and have them locate the appropriate attending on-call
4. contact the attending on-call for the division, again through the answering service (66400)
5. contact the fellow on-call for the service
6. if all else fails, contact the chief resident

Digital Access

Email
- All residents are given an email address using Microsoft outlook: first.last@lumc.edu.
  - You may access this email using the Outlook program on the desktop of hospital computers or on the EMR link under “Trinity Outlook” tab: (http://emr.lumc.edu).
  - You may also use the direct web address: https://owa.trinity-health.org. From home, you may also access email via: https://apps.luhs.org.
- Much of the departmental communication takes place using this email system, and you should expect to check it daily.
  - The CRs send out a weekly Friday email with important information. You are responsible for the information that is emailed to you.
- It is possible to upload your Outlook email onto your smart phone, and that is recommended so that you do not have to miss any important information or urgent requests.
  - Directions can be found for iphone/ipad/android/windows phone by logging into the EMR, then clicking on the “helpdesk” tab at the very top. Look on the left-hand side for the “LUMC MS Outlook” tab. To make it easier, you may also follow this link: http://www.luhs.org/internal/depts/mcis/td/cus/mer_web/lumc_msoutlook_2010.cfm or call the helpdesk for more assistance (x62160).
  - There are directions for iphone, android, and windows phone. Again, the Department of Medicine highly encourages you to have your work email on your phone for easy access.
- Please note that former Stritch students might still have an active email account: login@luc.edu but that email will NOT be used by the IM department.
**Home Access for EPIC and CPRS**

- **EPIC:**
  - To access EPIC: [https://www.apps.luhs.org](https://www.apps.luhs.org). You will need your Loyola login and password to be connected.
  - If you would like to install EPIC on an iphone or Mac product, information can be found on this link: [http://www.luhs.org/internal/depts/mcis/tsd/customer_web/mac_corner.cfm](http://www.luhs.org/internal/depts/mcis/tsd/customer_web/mac_corner.cfm). You will need to set this up from a Loyola Computer. Lots of other useful information related to IT at Loyola can be found on the emr.lumc.edu website. At the top of the page, click on the helpdesk link.

- **CPRS:**
  - For Hines home access, please contact LaWanda Rucker at 708/202-8387 x24564 for information or contact the Hines CR.

**Resident Pagers**

- **Distribution:**
  - Resident pagers are distributed and collected by our Program Coordinator, Steve White. Each resident will be assigned a Loyola pager on Orientation Day, and this pager will be carried by the resident through the duration of his/her residency. Pagers will be collected at end of the PGY3 year. Steve can help you with any pager questions. Paulette Campos, Administrative Assistant to Dr. Simpson has extra batteries if your pager battery needs to be replaced.

- **Accessibility by Pager:**
  - All residents should make every effort to respond to all pages immediately. This includes pages received while both in the hospital and at home. If you are no longer in the hospital or are unavailable then it is your responsibility to appropriately forward your pager.
  - Please remember to change your pager status to “unavailable” when you are on vacation or a night float rotation to avoid being woken up. This also helps the staff and clinic triage nurses know that you are not available for patient care calls (they will then contact the attending). You may also forward your pager to a colleague during this time.

- **Pager Repairs:**
  - Pagers needing repair can be taken to the Parking Office in Mulcahy Building.

**Social Media**

While social media can be an important way for housestaff to keep in touch with family and friends, residents are encouraged to limit the use of this format to times when they are not in the hospital/clinic taking care of patients. Similarly, housestaff is reminded that it is never allowed to mention any patients, even generally, in any online format as this is a violation of HIPAA. Such instances can be cause for suspension or immediate dismissal. In general, hospital/facility names and similar identifying features should be left off of social media posts to avoid accidental HIPAA breaches and maintain professionalism.

The view the full policy, go to Loyola.wired on the portal under Administrative Policy Manual: COMP 39

To summarize:

- Colleagues must never post information or photos related to a patient’s care or our fellow colleagues on social media websites.
- Colleagues should not make negative or unprofessional remarks about the organization or co-workers on social media at any time. This applies while on a work device or a personal device.
- LUHS work stations may not be regularly used to access the Internet for non-work related purposes. Access to the internet for non-work related purposes must not interfere with job duties, and/or patient care, or occur in areas visible to patients. Uses may not access websites that are inappropriate or offensive.
- When using social media and discussing topics where your affiliation with LUHS is known, you must indicate that the views expressed are yours alone and do not represent the views of LUHS.
- Violations of our policies will result in disciplinary action.
Resident Documentation

General Principles

1. Documentation is necessary and important for patient care.
   a. Information regarding important events, patient preferences, test results, diagnoses, treatments, complications, and physicians' plans improve quality and continuity of care
   b. Necessary for billing and reimbursement
2. Each new patient encounter requires a thorough history and physical exam, as appropriate.
3. The ideal note provides a clear story, relevant findings, and communication of the physician's diagnostic and therapeutic considerations.
   a. Another healthcare provider should be able to read this note quickly AND be able to understand the medical decision making involved.
4. The purpose of housestaff documentation is to facilitate excellent patient care and education.
   a. While documentation has a role in elements of billing and reimbursement, this is not the primary responsibility of housestaff.

| Do: | Do Not: |
|---------------------------------|
| Provide summary of events/subjective since the prior day | Write "no complaints" and nothing more in subjective section |
| Include relevant information concisely | Copy-forward dated, no-longer-relevant reports and dense pre-populated labs |
| Update physical exam daily | Include physical exam that you did not complete |
| Update A/P daily to reflect current status and plan | Copy entire A/P into subsequent notes without edits |
| Include service name, supervising attending, code status |  |

Specific Guidelines

1. Admission H&Ps
   a. Responsibilities
      i. Each patient should have an H&P Admit note when admitted.
      ii. An intern H&P must be addended by a senior physician before the end of their shift
         1. This can be a senior resident, a fellow, or an attending physician
   b. Content
      i. Must include chief complaint, HPI, PMH, SH, FH, Meds/Allergies, PE, Labs/Micro, Imaging/Studies, A/P, and code status
      ii. Senior addenda:
         1. Must include:
            a. A statement that you have personally seen/evaluated patient
            b. Admitting diagnosis
            c. Short summary of presentation and findings
            d. Brief plan
         2. Do not need to include a detailed physical exam, medication reconciliation, etc.
         3. This may be an independent note rather than an addendum if the intern's note is not complete/signed
      iii. A/Ps
         1. All problems that require orders or medical decision making must be documented, in order of importance
2. For each acute problem, include a differential diagnosis and justification followed by diagnostic and therapeutic plans
3. For chronic problems, it is appropriate to briefly mention current state (e.g. controlled vs. uncontrolled) and current management (e.g. "continue metoprolol")

2. Progress Notes
   a. Responsibilities
      i. All admitted patients must have a daily progress note
      ii. It is the expectation that these are written by the PGY1(s) on service, up to a maximum of 10 notes per intern per day
      iii. It is the goal that all progress notes are completed by 2pm
      iv. For patients admitted overnight with an H&P signed after midnight, it is sufficient to write a post-rounds addendum with brief update of events and plan of care.
   b. Content – "Can I read this note and assume care of the patient?" Include current clinical status and care planning
      i. Subjective – overnight events, current symptoms, status (better, worse, etc.)
      ii. Objective – vitals, exam, labs
      iii. A/P – this should be updated daily
      iv. Any significant events that occur after the progress note is signed may be added as an addendum

3. Crosscover
   a. Responsibilities:
      i. It is the intern's responsibility to document any significant clinical event/change that occurs during their shift, including (but not limited to):
         1. New diagnostic finding that results in change in management
            a. e.g. CT PE is positive and heparin drip is started
            b. e.g. Patient develops sepsis and antibiotics are started
         2. Any decompensation or significant change in clinical status
            a. e.g. Patient desaturates, is started on O2, and CXR ordered
         3. Any significant conversation had with patient or family
            a. e.g. Family tells you they want to transition to comfort care
         4. Any transfer to a different level of care/service
            a. e.g. Alcohol withdrawal patient is transferred to step-down at Hines due to high benzodiazepine requirements
   b. Content
      i. A brief narrative of the events is appropriate with inclusion of relevant details such as time course, interventions, labs/imaging, etc.
      ii. At Hines: include primary team as "additional signers" so they receive a notification of your note

4. Discharge Summaries
   a. Responsibilities
      i. Interns are expected to complete discharge summaries within 24 hours of discharge
      ii. If a patient dies overnight, it is the responsibility of the daytime team to complete the discharge summary
   b. Content
      i. Hines: use the discharge summary note and template under the "D/C Summ" tab
      ii. Loyola: write a note titled "Discharge Summary" using the SmartText "IP DISCHARGE SUMMARY NOTE"
iii. A discharge summary may take the place of a progress note if it includes **vitals** and a **physical exam**

iv. Include a list of primary and secondary diagnoses

v. Summarize the hospital course *succinctly* - PCPs and other physicians the patient sees for follow-up will use this to help guide their treatment

vi. Clearly indicate any follow-up needs (e.g. labs, imaging, medication monitoring, etc.)

5. **Procedures**
   a. Responsibilities
      i. The following procedures require a procedure note: arterial line, central line, lumbar puncture, arthrocentesis, paracentesis, and thoracentesis
      ii. Any member of the team may complete the procedure note
      iii. Hines: each procedure has a dedicated note (e.g. "Central Line Note" or "Thoracentesis Procedure Note") except arthrocentesis and paracentesis; you may use a generic "General Medicine Procedure Note" for these
         1. Templates in the process of being edited
      iv. Loyola: create a note labeled "Procedures" and indicate which procedure was completed in the field provided. Use the appropriate SmartText by searching in the box (e.g. searching "arterial" produces the "IP ARTERIAL LINE PROCEDURE NOTE")
         1. FOR CENTRAL LINES: use the SmartText called "CLIP NOTE" which will import information from the CLIP flowsheet
   b. Content
      i. While templates generally include the necessary details, please ensure your notes have the following information:
         1. Name of person doing the procedure
         2. Name of person supervising the procedure, if applicable
         3. Attending on service
         4. Procedure name
         5. Indication
         6. Procedure description
            a. Include documentation of informed consent, sterile technique/draping, use of anesthesia (typically local)
            b. This reads like an operative report!
      7. Complications
      8. Samples sent

6. **Medical Student Notes**
   a. These do not count as daily documentation yet, but might in the near future.
      i. Until we are notified differently by the Hospital Administration, assume med student documentation does not count
   b. There MUST be an independent note from a resident physician

7. **Special Situations**
   a. Rapid Response (RRT)
      i. Hines: residents are required to write a brief note summarizing the rapid response using the "Rapid Response Team Note" template
      ii. Loyola: documentation is encouraged but not required. A brief crossover-like note would be appropriate.
b. Code Blue  
   i. Hines: residents are required to write a note using the "Code Note" template.  
   ii. Loyola: A note documenting the code should be entered in a crossover-like fashion. A template for Code notes is currently being developed.

c. Death  
   i. Hines: residents are required to write a note using the "Death Note" template. You must document a physical exam.  
   ii. Loyola: residents are required to write a note titled "Death Note" using the SmartText "IP DEATH NOTE"

8. Cutting and Pasting Policy  
   a. In general, the cutting and pasting of one’s own note into another is highly discouraged. This practice leads to misinformation due to lack of updating when information is carried forward from day to day. This practice can also lead to redundancy and confusion.  
   b. You are prohibited, due to hospital policy, from cutting and pasting another’s note into your note. In the rare instance this needs to be done for any reason, you must state that you are doing so and give credit to original author.  
   c. For complete Institutional Policy on this topic, please refer to:\  
      i. http://data.luhs.org/?key1=8065F676-68C9-410E-A6EF-E11D3DC55CA9&key2=63913CDE-A0B7-45A8-ACBC-127873BF5AA1

**Code Status**

In general, a DNR discussion needs to take place with all inpatients and documented as such in the chart so that the ‘code status’ is made known to all those involved in patient care.

At Loyola, the DNR policy can be found on the Loyola Portal under the Policies tab, then Patient Care Manual, the resuscitation. It may also be accessed here: [DNR Policy](#)

At Hines, effective 5/1/2018, there is a new policy in place for documenting life-sustaining treatment preferences and conversations. This policy is known as the "Life Sustaining Treatment Decisions Initiative" (LSDI). To document code status, you will select the "Life Sustaining Treatment" note in the Notes tab of CPRS. Any preferences documented in this note will then generate orders for the patient (ex, "Patient would like full resuscitation measures", "Patient does not want artificial hydration"). For more information on the LSTI note and order set, including a step-by-step guide for documentation, please see the Loyola IM residency website. Additional information can be found in this Powerpoint guide below (simply click on the picture to watch the .ppt presentation).
Resident Work Hours & Logging

**General Information about Rotations:**
All medicine interns and residents follow the “4+1” schedule. The four weeks will be made up of varying assignments (i.e. inpatient service, consults, night float, research etc.). The “+1” for categorical medicine and med/peds residents will consist of an ambulatory week. For preliminary year and neurology clinical base year interns, the “+1” week will vary between inpatient consults, ambulatory clinics, and other uniquely designed experiences (see section about Plus One Weeks below).

**Work Hour Restrictions:**
The Department of Medicine takes duty hours very seriously. It is the responsibility of the *intern and resident* to make sure they are in compliance with the ACGME restrictions. The faculty, fellows, and administration are in full support of the following:
* Housestaff may not work more than 80 hours per week averaged over the month
* Must have 1 day off in 7 averaged over the month
* Residents (PGY 1,2,3s) may not work more than 28 hours in a row
* Residents cannot accept any new patients after 24 hours of duty
* Residents must have 14 hours off after a 24 hour shift

**PLEASE bring any work hour concerns to the attention of the Chief Residents immediately** so any potential work hour violations can be avoided proactively. The importance of complying with all duty hour requirements cannot be overstated. Dr. Melissa Briones is the APD who specifically monitors duty hours for compliance. Violations are not viewed in a punitive fashion, but rather to ensure that rotations are running in a way that allows residents to comply with these important rules.

**Logging Duty Hours:**
Logging of duty hours is a requirement of *all residency programs by the ACGME*. All residents are required to log their duty hours into New Innovations on a weekly basis (https://www.new-innov.com/login/). Any duty hours violations will subsequently be reviewed in real time so that program, resident, or rotation specific issues may be addressed by the leadership team in a timely manner. Failure to log duty hours will initially result in a reminder from the chief residents, and failure to comply at that point may result in escalation to the Program Director or the Clinical Competency Committee.

**Work hours:**
- Residents and interns need to arrive for work at 6am on all rotations except Geri/Consults/Night Float/Research/Ambulatory Weeks.
  - Residents and interns on Geri/Consults/Night Float/Research/Ambulatory Weeks are expected to arrive at the designated time listed on the IM Residency webpage under the specific rotation.
- At least one resident or intern from each team is expected to stay until 5pm to sign-out their team to the night float intern. At least one senior resident from each group (CCU/Cards/CHF; L-MICU; L-GM/Hep; H-Heme Onc/Cards/MICU) is expected to stay until the night float senior arrives.
- On weekends, residents may sign-out no earlier than noon.

**Admissions:**
Interns are expected to do a minimum of 50 admissions during their intern year. It will be up to the intern to record the appropriate patient data on New Innovations. Directions for logging this information are available in the Intern Manual/Survival Guide.
- Failure to meet this admission expectation will result in a designation of "Critical Deficiency" in the Professionalism Milestone as reported to the ACGME at the conclusion of the year.

**Census Information:**
The CRs keep track of all census information for each rotation at both hospitals (number of pts on the team, admissions, etc.). It is the primary responsibility of the senior resident to record daily census information on designated calendar.
Absences

All residents are expected to arrive to their assigned rotation on-time and as scheduled. If an emergency arises that would prevent a resident from being at his/her assigned rotation on time, the resident MUST notify the Chief Resident immediately.

- Absence procedure
  - For any emergency/unanticipated absences, the resident must page the 24/7 on-call chief pager (#10297). Notification via text, email, or phone is not acceptable. There must be closed loop communication of all absences between the resident and the Chief Resident.
    - It is not acceptable to notify the team (co-resident, intern, fellow, attending) in lieu of notifying the Chief Resident. Once a phone conversation with the Chief Resident takes place, the resident can then reach out to the team.
    - Again- first call if a resident will be late or absent is to the Chief Resident. MUST be a phone call. No text messages/text pages/voice mail is appropriate.
  - If a resident anticipates a need to be absent from clinical assigned duties due to an urgent situation, the resident must contact the Chief Resident ASAP, with a discussion about which day would be most appropriate if there is any flexibility.
    - The Chief Resident will then determine if jeopardy coverage is needed and will ensure all applicable personnel are informed.
- Additional information can also be found under the Vacation/Time-off Section below.

Vacation/Time Off Policy

You will find the Loyola GME (Graduate Medical Education) policy at: https://www.loyolamedicine.org/gme/current-housestaff under the Resident Handbook (starting at page 65). You are responsible for the material within the GME Handbook. The following are brief highlights of that information.

*Please note: Residents may be required to delay their date of graduation for any leave beyond 4 weeks of vacation annually. This is determined on an individual basis and must be discussed with the program director.

1. Work Absence:
   a. If a resident is unable to come to work they must page the chief resident pager (#10297) immediately. There must be closed loop communication with a chief resident confirming the absence. Email communication of an absence is NOT permitted.
   b. The intern/resident must also notify their team members, however communication with team members alone is not sufficient. You must communicate with a chief resident.
   c. Absence from work without closed loop communication with a chief resident will lead to a meeting with the Program Director and possible disciplinary action
   d. If a resident is sick more than 2 consecutive days, it is GME policy that he/she must see a physician for evaluation and a return to work note prior to returning to service.

2. Annual Vacation and Educational Leave:
   a. Vacation requests are taken at the beginning of the academic year.
   b. 4 weeks total per year per GME policy, encouraging 1 week to be used for educational endeavors (but not required).
      i. Generally, these are allotted in one 2-week block and two 1-week blocks
   c. All requests to change a vacation need to be discussed with/approved by the scheduling chief resident.
d. Residents presenting at a conference should submit their request to the CRs for time off at least 90 days in advance. Each request will be individually reviewed by our leadership team which reserves the right to approve or disapprove based upon scheduling implications.

3. A vacation taken during the last week of June during the last week of one’s residency is known as a **Terminal Vacation**.
   a. While it is common for many senior residents to request this week off, it is impossible for all graduating residents to be absent at the same time.
   b. The CRs will send out a terminal vacation request form to all graduating residents in late winter/early spring. Requests for a terminal vacation will then be reviewed by the Chief Residents and PD on an individual basis.
   c. The right to refuse a terminal vacation is retained by the Program Director.
   d. Please note that time off at the end of June will only be considered if there is actual vacation time left for the resident.

4. **Vacations during Ambulatory Week:**
   a. 1. Residents can request **no more than one week** of vacation and/or educational leave during an "ambulatory week" period **over the course of his/her residency**.
   b. Residents requesting vacation during an ambulatory week should contact both the inpatient scheduling chiefs and the ambulatory chief resident when scheduling preferences are due.
   c. 3. If you are approved for vacation during your ambulatory week, you must inform Dr. Laura Ozark and your *Friday School* facilitator that you will be missing Friday school.
   d. 4. Notice of planned absence from clinic must be given to the clinics at least 30 days in advance for LOC/ATC clinics and 45 days in advance for Hines clinic. This is a hospital policy and applies to all physicians. Cancellation requests less than the above number of days **cannot be honored**.
   e. You need to contact the Ambulatory Chief Resident if you need to have a clinic cancelled.

5. **Time off for fellowship/job interviews:**
   a. All requests for days off for interviews must be submitted to the CRs **as soon as** your interview date is confirmed to discuss coverage options.
   b. When possible, interviews should be scheduled on non-service rotations and **not** during the residents’ continuity clinic week.
   c. A resident will only be allowed up to 12 work days off for interviews. Any days over 12 will be deducted from remaining vacation days.
   d. You may only miss one Friday School throughout your residency (vacation during a +1 week is included in this). Requests for fellowship interviews on a Friday will be allowed if there have been NO other missed Friday schools during your residency. Additional requests to miss Friday school require discussion with Dr. Ozark.

6. **USMLE Step 3/COMLEX examinations**
   a. -Residents should schedule their step 3 exam during their non-service time (ie- consults or vacation). Service, clinic week, and night float should be avoided.
   b. -Time off (2 days total) must be approved by the CRs prior to scheduling your exam. Residents should contact the scheduling CRs as soon as they are assigned a scheduling 'window'. Do not wait to contact the CRs until after you have made your final selection as your dates may not be approved.
7. **Extended Leave:**
   a. Please refer to the GME handbook for questions about extended leave (maternity/paternity leave, FMLA, extended sick time, etc). [https://www.loyolamedicine.org/gme/current-housestaff](https://www.loyolamedicine.org/gme/current-housestaff)

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### Jeopardy

1. Jeopardy is a back-up system that is utilized when residents who are scheduled to work are unable to do so. This can either be for an emergency/unanticipated absence or, in very limited cases, an anticipated absence:
   a. **Emergency/unanticipated**
      i. Personal illness
      ii. Illness of a family member
      iii. Personal hardship (death of family member, damage to property, etc.)
      iv. Continued work would violate ACGME rules
   b. **Anticipated, subject to approval by CR/PD**
      i. Urgent medical appointments
      ii. Academic exams

2. Every categorical PGY2/3/4 resident will be assigned to a period on “Jeopardy,” generally 1-3 weeks a year.
   a. At any given time, there are 3 residents assigned to jeopardy.
   b. One month prior to start of jeopardy, this group of residents will receive an email to create the Jeopardy schedule (i.e., which resident is 1st, 2nd, and 3rd call each day).
   c. The completed schedule is due to the Chief Residents (CRs) no later than 1 week prior to assigned week.
   d. If a resident is unable to guarantee availability during their assigned week they must notify the CRs and secure appropriate coverage.
   e. All assigned residents must be available by cell phone and pager 24 hours a day.
   f. All assigned residents must be able to report to work, unimpaired, within 1 hour of notification.
   g. If a resident is called for Jeopardy, then they will be moved to the bottom of the call list for the next day. Thereafter, the schedule remains the same as prior.

3. If it is discovered that a resident is absent without notifying the CRs or is using Jeopardy for reasons outside of the sanctioned reasons above, additional shifts may be assigned and a 'Professionalism' violation may be designated at the upcoming Clinical Competency Committee meeting.

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### Random/Resident On Call (ROCs)

1. Residents on Night Float rotations work in two-week blocks and have one night off per week (on Friday night). The “Random On Call” or ROC provides coverage for this night off.
2. ROCs are primarily embedded within service months (e.g., a General Medicine resident will do a General Medicine night ROC during their general medicine rotation). Because of limitations of the schedule, some ROCs will not be embedded.
3. The ROC schedule is published at the beginning of the year. Every effort is made to keep the number of ROCs assigned even within each PGY class.
4. Changes to assigned ROCs
   a. **ALL ROC switches must be approved by Chief Resident (CR)**
      i. CRs will ensure that switches do not cause other scheduling implications
      ii. The program must know which residents are assigned to what rotation at all times
      iii. AMION and our master schedule need to reflect changes
   b. If the above notification is not done, additional shifts may be assigned.
Conferences

There are many conferences offered throughout the week for the residents. Attendance is expected while on all rotations (except when noted below). Make sure to sign in to each conference you attend.

1. General Medicine Morning Report (for all housestaff assigned to a Gen Med team):

   ➢ All gen med teams need to be present and ON TIME.
     ▪ Loyola: generally Monday, Wednesday, and Friday at 8:15am in Foley Library
     ▪ Hines: generally Monday, Wednesday, and Friday at 8:15am on the 14th floor room 1492

2. Noon conferences: (the specifics are subject to change)

   ➢ Summer Lecture Series: Monday, Wednesday, Thursday, and Friday in July-August (locations vary in the medical/nursing schools). This daily conference focuses on high yield topics for entering interns and a nice review for the seniors. Attendance is mandatory for all interns (except on vacation or night float).
   ➢ Selected noon conferences are posted online for those who are unable to attend due to vacation or night float
     ▪ Noon Conferences

   a. Monday and Wednesday: (September – June)

      a. Clinical Questions Conference (“CQC”):

         • One Wednesday of each month 12-1pm (replaces the usual Wednesday conference)
         • This conference is given by all PGY1s who will be assigned to a date to give this conference during a non-service rotation.
         • 3 interns present per Wednesday
         • Presentation is 10-15 minutes (about 12 slides) based on a focused clinical question that has arisen during the year.
         • The expectation is that a thorough review of the literature is conducted and a concise presentation is constructed.
         • The goal of the talk is to improve the ability to review the literature and then convey that information to peers in a succinct manner.
         • Interns are expected to contact Dr. Dayal one month prior to the conference to discuss potential topics (amit.dayal@va.gov or amitdayal17@yahoo.com) and to discuss the format.
         • The power point presentation will need to be reviewed the week prior with Dr. Dayal.

      b. Miscellaneous Topic Conferences:

         ➢ This year we are shifting towards a more interactive lecture series hosted by the various CRs

   b. Tuesday: Internal Medicine Grand Rounds

      • Every Tuesday at noon in Tobin Hall in Medical School for all Department of Medicine faculty and housestaff
      • Hosted by sub-specialty departments
      • Attendance is required regardless of rotation
c. **Thursday: Clinical Pathological Conference ("CPC")**

- September through May
- This is the premier conference of the residency program presented by all PGY 3s and MP PGY4s
- Attendance is mandatory. If residents do not attend >50% (25% for med ped), they will be given an additional ROC (or equivalent for interns/prelims) as a consequence.
- Graduating residents present a complicated and in-depth conference focused on a medical case with multiple teaching topics interspersed
- When residents come across an interesting case, they should email the outpatient chief with the MRN to “reserve” it.
- A detailed schedule will be made at the beginning of the year based on each resident’s schedule.
- A detailed timeline will be distributed at the May Workshop for current PGY 2s and is also found on the website: [https://www.loyolamedicine.org/gme/internal-medicine-residency/resident-resources/pgy-3-retreat](https://www.loyolamedicine.org/gme/internal-medicine-residency/resident-resources/pgy-3-retreat)
- Presenters must meet with a member of the CPC advisory board (Drs. Czerlanis, Derhammer, or Kristopaitis) early in the planning phase
- Residents should also be meeting with subspecialties: pathology, radiology, etc prior to their presentations
- They should also meet with a chief resident to go over the final presentation according to the timeline

d. **Friday: Autopsy/ Patient Safety Conference**

- Fridays at Noon at the Hines Veterans Hospital E347
- Autopsy/Patient Safety Conference is a weekly academic case conference presented by a PGY2 Internal Medicine or M/P resident
- Residents are assigned the case of a patient who underwent autopsy after dying in the hospital and are responsible for preparing and presenting the case to a wide Internal Medicine audience to foster academic discussion about the patient’s clinical course, lessons learned from the case, and academically challenging topics.
- Residents may opt to present a Patient Safety Conference in lieu of an Autopsy Conference in which they review a clinical case that includes teaching topics and discussion points about quality improvement (systems-based care, team-based care, protocols, communication, etc.)
- The conference serves as a bridge between the intern year’s Clinical Question Conference (CQC) and the culminating experience of 3rd year, the Clinical Pathophysiology Conference (CPC)
- Residents are expected to prepare in the month before their assigned date for presentation. They should contact the assigned pathology resident about 3 weeks beforehand and actively discuss the case with them. They should meet with the Autopsy Conference advisor, Dr. Bryan Gee, about 3 weeks beforehand, who will guide them in their preparation until the conference. The conference is attended by a wide group, including fellow residents, medical students, and attending staff in general medicine and the subspecialties.

3. **Subspecialty Lectures:**

- Some divisions have organized a lecture series while on those rotations (i.e. MICU, nephrology, cardiology, heme/onc). These conferences are required and information will be provided prior to your rotation. Additional information can be found on the residency website under the specific rotation.
Plus One Weeks (4+1 system)

Also called "ambulatory weeks," these weeks are unique in our 4+1 system and differ among preliminary residents, med-peds residents, and categorical residents. All residents will attend Friday school for a ½ day during this week.

Categorical Interns/Residents

A. Continuity Clinic:
All residents will be assigned to Hines, Loyola, or Access to Care (ATC) for their continuity clinic. These clinics consist of five ½ day clinics. According to the RRC, all residents are required to do a minimum of 130 clinics over 3 years. Each clinic session should have: 3-5 patients for interns, 4-6 patients for PGY2s, and at least 4 patients (no maximum) for PGY3s.

- Residents are allowed to have no more than 1 clinic week cancelled throughout the three years of residency for vacation. This request needs to be approved by the outpatient chief resident and the respective attending for the clinic site (Dr. Gee for HVA, Dr. Fitz for ATC, or Dr. Sisbarro for LOC).
  - Hines Clinics need at least a 45 day notice to cancel clinic
  - Loyola & ATC need at least a 30 day notice to cancel clinic
- Residents are responsible for checking and answering all EMR inboxes and secure messaging DAILY. These are how patients and nurses communicate with you (CPRS at Hines and EPIC at Loyola and ATC) and is the primary means for communicating patient calls, Rx requests, lab results, consults, etc. In general, you will not be paged when a patient calls you; a note will be placed in EPIC or CPRS. Therefore, it is necessary to check this each day so that you may return patient calls and requests for medications, advice, etc. in a timely fashion.

- Computers off-campus (home, Hines, etc.) can access EPIC via https://apps.luhs.org webpage.
- Only certain computers at Loyola can access Hines VA using your PIV card. These computers are in the 6th floor call rooms and the 7th floor resident work room. Instructions are on a paper sheet close to the computer. The Ambulatory Chief Resident can assist you with access.
- You are responsible for having remote access for your clinic in order to check alerts when on service at the other hospital.

- Both Loyola and Hines have important introduction documents you will receive on the first day of clinic with clinic-specific information and policies. These documents are also available on the IM Residency Website Curriculum page under "Ambulatory".
- There are clinic curricula that will be completed prior to the start of clinic on select days. The material is on the IM Residency Website. All articles and cases should be prepared prior to the clinic session.

B. Subspecialty Clinics:
- Over the three years, a resident is required to have an experience in each of the 5 Core Specialty Clinics: Rheumatology, Endocrinology, Oncology, Pulmonology, & GI/Liver.

  - **PGY-1** residents will be placed in a “block” system for their intern year.
    - Interns will be assigned to:
      - 2 core clinics per +1 week
        - These core clinics will take place before/after their continuity clinic
        - Will have 1 core clinic in the first half of the year
        - Will then be assigned into another core clinic in the second half of the year
      - 1 elective clinic based on their requests
      - 1 half day will be set as an ‘administrative day’ (see section below for full details)
• PGY2&3s will have 3 half day sessions opposite their continuity clinic and 1 administrative half day.
  
  ➢ **PGY-2**
    • A block of 2 core clinics per +1 week
      ➢ Will experience 1 core clinic in the first half of the year
      ➢ Will then be assigned into another core clinic in the second half of the year
    • 1 subspecialty elective ½ day that can consist of
      ➢ A subspecialty clinic experience based on their requests
      ➢ Alternative experiences including:
        • Outpatient neurology: this experience will replace the PGY 3 inpatient neurology experience, freeing up 2 weeks of time from PGY 3 year for non-essential inpatient consults
        • Loyola Emergency Department: a six-hour shift in the Loyola ED which can free up two weeks of time for inpatient consults
        • Research for those residents who were approved for dedicated research time (either a Research Block, Resident Research Scholar, or QI Scholar). This is in addition to your assigned research blocks.
          ♦ An individual can complete both as a PGY2 and PGY 3
        • QI Certification: Participating in a formal QI curriculum of web-based activities that will grant an official designation on the graduating residents’ diploma in QI proficiency
          ♦ Can only be completed once as either PGY2 or PGY 3

• **PGY3s**
  • 1 core clinic per +1 week
  • 2 elective experiences consisting of
    ♦ At least 1 subspecialty clinic based on their requests
    ♦ The option of alternative experiences (please see above) including
      • Outpatient Neurology
      • Loyola Emergency Department
      • Research
      • QI Certification

• **Absences from clinic duties**
  • *An unexcused “no show” to clinic is a breach of professionalism and can result in disciplinary action.*
  • *If you are sick, you must page/call a chief resident to let them know.*
    • All communication should be a closed loop, meaning a phone conversation must take place. You may NOT just send a page or a text and assume it was received.
    • You should also contact your clinic attending to let him/her know you will not be there, since often additional patients are booked based on a resident being in clinic.
    • This should not be a frequent occurrence.
    • Additionally, if an attending does not have patients scheduled for the assigned subspecialty clinic a resident is scheduled to attend, it is the resident’s responsibility to alert the chief resident at least one week prior to the clinic week so a replacement educational experience can be found.
      • Not alerting a chief resident of a cancelation is considered an unexcused “no show”.
**Preliminary Interns**

+1 week will be filled with a combination of inpatient medicine subspecialty consults and custom specialty rotations.

- Interns will fill out a preference form for custom rotations after matching. Once the inpatient consult rotations are scheduled, these custom rotations will be coordinated and scheduled by the outpatient chief as available.
- The preliminary year interns will continue having a protected “golden weekend.”
- The preliminary year interns will have an Administrative Half Day given during their +1 week (see below).

**Med-Peds Residents**

- Have at least one ½ day continuity clinic per week in addition to Friday School, but will also have various other experiences in the +1 week:
  - **PGY1-2 (16 month internship)**: Complete 6-8 weeks of urgent care and ER experiences during the +1 weeks
    - Urgent care shifts are assigned to accommodate Fri school and continuity clinics
    - The ER experience requires proportional day, night, and weekend shifts to categorical residents
  - **PGY2-4s (seniors):**
    - Administrative ½ day: *(see above)*
    - Private Practice experience in Hickory Hills: ½ day required, full day optional
    - Access to Care Clinic: ½ day optional opportunity if available
    - Specialty experiences:
      - Core specialities: Rheum, Endo, and electives
      - Med Peds Specific: Adolescent Gyne, Congenital Heart, CF/transplant, Sickle Cell, H/O Survivorship, Sports Med, HIV, Allergy/Immunology, Ophtho, ENT, Derm, Neuro, Palliative
    - Elective Research/QI week: Four ½ day sessions will be dedicated and will require a qualifying IRB project or QI certification curriculum enrollment.

**Administrative Half Day:**

- All Categorical and Preliminary interns and residents in our program will be assigned an "Administrative Half Day" during their +1 week.
- This ½ day (approximately 4 hours) given during each +1 week will be free from direct patient care and is designed to allow time to complete professional tasks related to clinic, patient care, program expectation,
  - These tasks might include tasks related to clinic (calling results to patients, refills, paperwork, clinic case prep, coordination of care with consultants, etc.)
  - This time can also be used to complete Friday School pre-work, ARC readings, Subspecialty curriculum, and/or Boards preparation.
  - The expectation is that this time (approximately 4 hours) will be used to handle patient care issues (calling patients, refill prescriptions, paperwork, clinic prep, coordination of care, etc)
  - Advisor meeting can take place during this Administrative Half-Day time
  - Evaluations for rotations should also be completed during this time
  - It is not necessary to physically be present on campus during this assigned time, however, the expectation is that residents will complete the expected Professional tasks (see above). If these tasks are delinquent, residents will be asked to physically remain on campus to fulfill basic program requirements.
Friday School/ Academic Half Day

1. Friday school is a ½ day protected academic time designed to provide our housestaff additional teaching and training on topics not covered in other areas of our program.

2. Each intern and resident will be assigned to a “Friday School” block and time.

3. Topics include simulation training, problem-based teaching, subspecialty topics and didactics, teaching curriculum, wellness topics, and MKSAP board review questions, among others.
   a. This is also a time to address program updates or mandatory education for the hospital or Department of Medicine. Please note that while the Academic Research Curriculum program (ARC) does take place during this protected time, it is a separate program from Friday School. Refer to the ARC section in this manual for additional details.

4. The categorical interns and residents will have their Friday School on the Friday of the +1 week opposite their continuity clinic time (e.g. morning clinic will have Friday School from 1pm-5pm, and afternoon clinic will have Friday school from 8am-12pm).
   a. ATC clinic, med/peds, and prelim/neuro interns are assigned to a Friday school to best balance the roster and other educational considerations. Rosters and session dates can be found on the residency webpage under the “Friday School” tab.

5. Often there will be reading or short activities to do prior to the session designed to enhance learning. A reminder email will be sent usually the Monday of the +1 week with specific session details.
   a. The content and any pre-work for Friday school is posted on the residency website under the Friday School tab at the start of the block in order to allow the resident to best plan ahead: [https://www.loyolamedicine.org/gme/internal-medicine-residency/resident-resources/friday-school](https://www.loyolamedicine.org/gme/internal-medicine-residency/resident-resources/friday-school).
   b. The administration half day will help allow dedicated time to prepare for any assigned work.

6. The 2018-2019 academic year will have 10 Friday School sessions which will cover a large curriculum; attendance is always required.

7. Housestaff may only miss one Friday School per residency and the Chief Residents, Dr. L Ozark and the Friday School faculty facilitator all must be notified of the absence.
   a. Please refer to the “Vacation” section for additional details. In the event that any resident is requesting to miss a 2nd Friday School during his/her residency, this request must be made to the Dr. Laura Ozark specifically, and will be reviewed by the Leadership of the program.

8. If there are any interested housestaff in working on a Friday School Curriculum Planning committee, please contact Dr. Laura Ozark.

Evaluation System

New Innovations
The electronic evaluation system that we use at Loyola is New Innovations. You will receive access to New Innovations during orientation with instruction on how to use it. During your different rotations, you will be asked to evaluate your peers, attendings, and the rotations themselves. You will receive e-mail notification from New Innovations when you have new evaluations to complete. Your feedback is vital to our program, so please complete your evaluations as quickly and professionally as possible. Resident feedback is consistently used to make improvements to different rotations, and it is also provided to attendings and your peers anonymously. In addition, you will be evaluated by your attendings, fellows, co-residents, nurses and social workers through New Innovations. This feedback will be available for you to review in your portfolio and discussed at advisor meetings. Please note that all evaluations are completely anonymous.

The CCC (Clinical Competency Committee) considers the number of incomplete evaluations any resident has when they are completing their bi-annual report. Failure of a resident to complete their assigned evaluations in a timely manner will result in a low score in the field of “Professionalism” in their CCC Performance Evaluation.
Resident Evaluations of Attendings
The leadership of the residency completes a lengthy annual evaluation of all attendings every August and provides this data and a summary to the Department Chair and Division Director as well as the faculty member. Information from the attending evaluations is compiled for the year and therefore is completely anonymous as to which resident completed the evaluation. The top 25% of attendings are designated to the “teaching honor roll” based on housestaff scores. If you have more serious concerns regarding an attending that should not wait a year, please speak with the CRs/PD/APDs.

Resident Evaluations of Individual Rotations
Individual rotation feedback is evaluated annually in February and presented to the Subspecialty Education Coordinator for that rotation. Changes to rotations for the following academic year are based on numerical evaluation data and comments provided. Again, these anonymous evaluations are looked at in the aggregate and it is impossible to track back to any particular resident.

Directly Observed Experiences
In addition to evaluations associated with the end of the rotation, there also are a number of Directly Observed Experiences (DOE) that will occur within rotations as well as in other settings. These DOEs are typically evaluations you will receive from an attending who observes you perform some task related to the care and management of patients. The goal of these DOEs is to give the evaluators greater insight into each resident’s skills, as well as to help provide more direct feedback to the residents. You will be reminded on different rotations of the need to complete certain DOEs.

Clinical Competency Committee
The Clinical Competency Committee (CCC) is comprised of faculty members of the Department of Medicine that meets six times each year to review evaluations of the residents. This committed is charged with assessing the progress of each of our residents, and to make recommendations to the Program Director regarding promotion of each resident. The CCC uses the 22 Internal Medicine reporting milestones to assess each resident’s performance and is responsible for this milestone data that is reported to the ACGME every six months. An overall summary statement is generated about each resident at each CCC meeting, and hand written on the cover sheet of your packet. You will meet with your advisor after each of these meetings to review the CCC packet (twice per year). Dates for these meetings can be found in your advisor packet.

On the Fly Evaluation
Should you wish to complete an evaluation on a colleague or attending whom you were not ‘assigned’ to work with formally (and therefore will not automatically be sent to you), you may do so through New Innovations. Questions about using New Innovations (NI) can be directed to Jill Wallock, Program Coordinator.

Resident Advising System
- All residents are assigned to a faculty advisor with who they will remain throughout residency.
- Meetings are held two times a year at a minimum. The resident will receive notification via email from that it is time to schedule an appointment with their advisor in the fall/winter, and spring.
  - The resident is then responsible for contacting his/her advisor and arranging a time to meet.
  - The resident will complete an Individualized Learning Plan (ILP) prior to the first meeting and then update at the subsequent meetings.
    - This self-assessment document will help the resident work on both long and short term goals.
    - A copy of the ILP is kept in their portfolio and updated at each meeting.
- All documents and advising program information and roster can be found on the department webpage:
- The date ranges for the advisor meetings are found on this website as well.
Resident Portfolios

- Every resident has a portfolio in Paulette’s office.
- The portfolio contains information relevant to your residency such as: resident contact information, annual contract, copies of temporary and permanent license/NPI numbers, BLS/ACLS cards, evaluations, Clinical Competency Committee (CCC) summary statements, letters of commendation, and more.
- You will be reminded to stop by the office minimally two times per year to review and sign all your evaluations as well as the summary statement from the CCC after this committee meets.
  - This is usually done during your semi-annual advisor meeting, but if you do not sign at that time, you can always stop by Paulette’s office.

Procedures

- Please note that in order to perform a procedure independently, a resident must be observed/supervised performing that procedure by a credentialed senior resident, fellow, and/or attending.
  - All of the procedures MUST be documented in New Innovations with the date, patient MRN, and supervisor listed.
  - Once an intern/resident has met the required number of supervised procedures listed in the table below, they will then be allowed to perform the procedure independently.
  - Procedures must be logged and signed by the supervisor, otherwise it will not be considered completed.
  - It is the responsibility of the resident to keep their procedure log current.
  - Nursing will confirm the privileges of a provider prior to initiating a procedure, and you may be prohibited from doing the procedure in the instance you are not "signed off."
  - Detailed information about the Procedure Policy at Loyola can be found at this link: [https://youtu.be/DmUrZUl6nlJ](https://youtu.be/DmUrZUl6nlJ) (a 6 minute video detailing this program)

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>NUMBER OF SUPERVISED PROCEDURES NEEDED BEFORE INDEPENDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial Blood Gas (ABG) Draw</td>
<td>(5)</td>
</tr>
<tr>
<td>Arthrocentesis (indicate site in comments)</td>
<td>(5)</td>
</tr>
<tr>
<td>Central Venous Line Placement</td>
<td>(5)</td>
</tr>
<tr>
<td>Central Venous Line Removal</td>
<td>(3)</td>
</tr>
<tr>
<td>Incision and drainage of an abscess</td>
<td>(3)</td>
</tr>
<tr>
<td>Intra-osseous line placement</td>
<td>(3)</td>
</tr>
<tr>
<td>Lumbar Puncture</td>
<td>(5)</td>
</tr>
<tr>
<td>Nasogastric Intubation</td>
<td>(3)</td>
</tr>
<tr>
<td>Pap Smear and Endocervical Culture</td>
<td>(5)</td>
</tr>
<tr>
<td>Paracentesis</td>
<td>(5)</td>
</tr>
<tr>
<td>Peripheral Venous Line Placement</td>
<td>(3)</td>
</tr>
<tr>
<td>Peripheral Venous Blood Draw</td>
<td>(3)</td>
</tr>
<tr>
<td>Thoracentesis</td>
<td>(5)</td>
</tr>
</tbody>
</table>

You will receive credit for 1 above procedure if you participate in a 'mastery level' simulation assessment for that procedure. Procedure will be entered by you, indicate this was a simulation, and put the sim evaluator as the authorized attending. These sim sessions change yearly, but have historically included: ABG, Central Venous Line Insertion, I/O Lines, and Peripheral Lines. It is the resident’s responsibility to ensure that this information is in New Innovations.

Instructions for logging procedures in New Innovations:
Once you have logged in:
1. On the tool bar, click Logger
2. Choose Procedures
3. For Patient ID, use medical record number
4. Use the calendar to record the Date Performed
5. Use Location to indicate Loyola or Hines
6. Select the **Procedure** performed from the drop down menu. If you select “Other”, record in the Comments box. You can also add additional information, such as location of a central line, in the Comments box. CPT Code is **not** required.

7. Select a **Supervisor** from the drop down menu. If the faculty is not listed, choose Dr. Simpson and make a note of who supervised the procedure in the Comments box. Click **Save**. *Let Jill Wallock know if your fellow or attending is not on this list.*

- In addition, the American Board of Internal Medicine (ABIM) states that internal medicine residents must be able to perform certain procedures competently as a part of their residency training, but only needs to be able to counsel, understand indications/complications, obtain informed consent, and interpret the results of many other common procedures (but not necessarily perform them).
- The IM residency program supports the ABIM’s requirements and offers simulation opportunities in the mandatory procedures if not addressed elsewhere. Experience and training of many common procedures are available while on specific rotations (eg Hepatology and paracentesis); some procedures are taught in the continuity clinic (eg pap/pelvic).
- ABIM’s procedure guidelines can be found at this link: [ABIM Procedure Policies](#)
- A short video explaining Loyola's bedside procedure protocols should be reviewed at least annually. It is on the GME website ([https://www.loyolamedicine.org/gme](https://www.loyolamedicine.org/gme)), or can be found directly using this link: [GME Bedside Procedure Video](#)

**Research Experience/Expectations**

- **Academic Research Curriculum (ARC)**
  ARC is a longitudinal research curriculum that focuses on teaching research methods, data interpretation, and critical analysis of published literature. The curriculum is focused around core journal articles, which are presented and discussed in small groups by dedicated research faculty during the Academic Half Day time (Friday School). Resident groups meet for an hour every five weeks with their designated faculty member. All categorical and prelim residents are required to participate.

- **Resident Research and Quality Improvement (RRQI) Program**
  The RRQI program is designed for residents who wish to pursue a more focused research or QI experience. It provides dedicated time in the schedule to allow residents to actively participate in research and QI projects. RRQI time is awarded in tiers based on the request of the resident and evaluation of the proposal by the leadership; each tier of RRQI is detailed below. If awarded research time, it will be allotted based upon non-service availability in the schedule.
  - RRQI Scholar
    - Residents who wish for the most extensive research/QI experience will apply for the RRQI Scholar program.
These residents must present a proposal of their project to a committee who will award the RRQI Scholar to the top candidates.

They will be eligible for up to 6 weeks of research time per year of residency in their senior years.

Up to 10 RRQI Scholars will be selected per year, split approximately evenly between research and QI.

Presentation dates:
- Research committee: early April
- QI committee: early April

- Research Associate
  - Residents can participate in research as a Research Associate by receiving up to 3 weeks of research time per year of residency in their senior years.

- RRQI Elective
  - Residents who would like RRQI time for a half-day in their +1 week can apply for an RRQI elective.

**Pre-requisites to dedicated RRQI Time**
- Submit a written research or QI proposal ([https://www.loyolamedicine.org/gme/internal-medicine-residency/resident-resources/research](https://www.loyolamedicine.org/gme/internal-medicine-residency/resident-resources/research)) to the Research Chief Resident or Chief Resident for Quality and Safety (CRQS) by early April. Exact dates on website and Friday emails.
- Complete CITI training by May.
  - *This is necessary to complete before you can be added to or submit an IRB, and it does take some time to process.*
  - Instructions are found here: [https://www.luc.edu/ors/citicourse/](https://www.luc.edu/ors/citicourse/)
  - CITI takes a few hours to complete
- IRB deadlines as listed below. **You must provide email confirmation from the IRB upon submission and approval.**
  - IRB must be submitted by June
  - IRB must be approved (or exempted) by **4 weeks prior to first RRQI time** (block or +1 week)
- If you are having issues with IRB submission, approval, or obtaining documentation, please contact the Research Chief Resident as soon as possible.
- Failure to complete these requirements will result in loss of RRQI time for that academic year.

**Expectations**
- Check in with the Research Chief Resident or CRQS quarterly to provide update on current status of research project(s)
- You must be available (i.e. "in town") Monday-Friday when on any RRQI block. Any exceptions to this must be cleared with Research/CRQS and Scheduling Chief Residents ahead of time.
  - Any breach of this rule will be documented as ‘unprofessional’ in your file and may result in disciplinary action including suspension or even dismissal.
- Research Scholars must submit a poster to ACP day in the fall if they had any research in the previous year.
- QI scholars must submit to the High Value Practice Academic Alliance conference.
- You must submit a poster to Resident Research and QI Day in May.
- QI Scholars are expected to present a Patient Safety conference in lieu of Autopsy Conference (PGY2) and include a QI/patient safety teaching topic in their CPC (PGY3).
- Submission of an abstract or poster to local/national conferences or for publication is strongly encouraged.
- Inform the Research Chief Resident or CRQS with any accepted abstracts, posters, or manuscripts
• **Research/Conference Funding**
  - Residents are provided with educational funds totaling $500/year in their PGY2 and 3 years. These funds are available for residents to use towards research expenditures as needed.
  - Further, the Department of Medicine will allow a senior resident (PGY 2,3,4) to apply for a total of $500 per residency to be used towards presenting their original research at a regional or national conference.
    - The research must have been done while at Loyola.
    - To apply for such funding, you must complete the research conference funding request form found on the Loyola website and send this to the Research Chief Resident at least 30 days prior to attending the conference.
    - The strength of the research and conference will be considered in the decision to grant funding.
    - In addition, adequate service/consult coverage must be arranged with the Chief Residents at that time.
    - If you have continuity clinic during the requested time, remember that we are only able to cancel clinic well in advance (45 days for Hines, 30 days for Loyola or ATC) so be sure to notify the Chief Residents as soon as possible.

• **Statistical Support**
  - Statistical support is available to residents through a partnership with the clinical research office (CRO); you must submit a project request form which can be found here [https://hsd.luc.edu/cro/](https://hsd.luc.edu/cro/).

• **Poster Printing**
  Funding for poster printing is available to residents presenting their research at a regional or national meeting. Instructions on poster printing as well as templates can be found at the following site: [http://www.stritch.luc.edu/tech_support/content/poster-printing-services](http://www.stritch.luc.edu/tech_support/content/poster-printing-services). Please contact the Research Chief Resident for the department code and billing information.

**Quality Improvement and Patient Safety (QIPS)**

**Quality Improvement/Patient Safety (QIPS) Longitudinal Curriculum**

- All Loyola Internal Medicine interns and residents are actively involved in QIPS initiatives throughout their residency.
- All interns participate in a year-long curriculum that introduces basic QIPS topics aligned with the Institute for Healthcare Improvement (IHI) Open School. The PGY1 curriculum, also known as *Tuesday School*, meets during some of the firms’ +1 weeks (see detailed schedule on first Friday School, or upon request). All residents participate in QIPS curricula that is integrated into Friday School.
- Interested senior residents can apply for the QIPS elective:
  - Residents participating in the QIPS elective are given dedicated 1:1 mentoring and small group time to discuss and work on their Patient Safety Conference (which they present in lieu of Autopsy Conference), an individualized patient outcome summary, and participation in a QI project. Time is allocated during the +1 week in place of one half-day subspecialty clinic.
  - Please note the following which are all **required**:
    - In-person meetings with mentor during the dedicated half-day
    - Presentation of a Patient Safety Conference (in lieu of Autopsy Conference)
    - Completion of retrospective chart review of ~80 patient outcomes of patients the resident provided care to during a one-month service rotation
- Poster presentation of Patient Safety Conference (PSC) including Individualized Patient Outcome Summary at Resident Research Day
- Collaboration with CRQS QI Project during dedicated half-day
- Completion of 13 IHI modules to receive IHI Open School Certificate
- Attendance at more than 50% of Housestaff Quality & Safety Committee (HQSC) meetings
- Participation in other QI/PS committees is encouraged, but not required

Professional Milestones

ACLS/BLS
- Current ACLS and BLS certifications are required for each resident. All interns need to have this course prior to starting residency. The certification is good for 2 years.
- Incoming interns need to take this course no earlier than April of the year they start our program (ie 2 months prior to starting their intern year).
- Only AHA certification for ACLS and BLS are accepted for Loyola Housestaff.
- The Department of Medicine assists in scheduling re-certification courses for the PGY 2 residents in the winter/spring prior to expiration to best fit into their rotation schedule.
- It is the resident's responsibility to follow through with registering for the assigned date. An email will be sent Dec-Jan of the PGY 2 with specific information. Steve White, program coordinator, will assist with this.

In-service Training Examination
- Each categorical resident is required to take an in-service examination in August/September.
- Interns and residents are assigned a date to take this computerized examination and are excused from clinical duties on this day.
- Percentile score will be reviewed during a meeting with the Program Director in January
- Interns and residents are encouraged to prepare for this examination as it can be a predictor for success for passing ABIM Board Exam following graduation.

Step 3
- We require all residents to take Step 3 prior to the start of their PGY3 year.
- Step 3 is required in order to apply for a permanent state medical license.
- Specific information about this is given at the PGY2 retreat in August.
- If a PGY1 wishes to take this exam, or otherwise needs information prior to that time, please contact Steve White, Program Coordinator.
  - He will assist all residents in completing paperwork and mail all documents.
  - The GME website contains helpful information.

Permanent Medical License
- A permanent state license is needed in order to work after residency (this includes fellowship).
- In general, residents who are pursuing fellowships wait until after the November/December Fellowship Match in order to start the licensing process.
- You should plan on applying for your permanent state license NO LATER than January of your PGY 3 year.
• Licensing information is given during the PGY 3 to-be workshop held in May of the PGY2 year.
• Steve White, Program Coordinator, will assist you in completing paperwork and mailing all documents.
• All states have different fees for permanent licensure. You might want to consider this when you are budgeting to take the exam and apply for licensure.
• The GME website has information regarding permanent licensure.

**ABIM Certification**
The board certification exam takes place each August. Any categorical internal medicine resident who chooses to be “Board Certified” must take this examination which is held on scattered dates during the month of August right after graduation. Registration for this exam starts December 1, 2018 and closes April 15, 2019. The current price is $1385. Additional information is available on [www.abim.org](http://www.abim.org). [Exam information link](http://www.abim.org).

The Department of Medicine supports its residents in preparing for this important examination in the following ways:
1. MKSAP books are purchased for all categorical interns
2. MKSAP questions are incorporated into most Friday School sessions with analysis on both the content of the questions, and strategies for answering Board questions.
3. Those residents felt to be “at risk” for lower performance on Boards are assigned an Associate Program Director to coach them as needed with study plan, timeline, etc. based on specific needs.
4. Board Review Course available for all PGY3s scheduled in the springtime (approx. $1000 value)
   A. Formal Board Review Course
      a. The Department of Medicine (DOM) will sponsor all third year residents to attend a formal board review course (ACP, Awesome Review, or other comparable approved course).
      b. Participation in a course will be required for all residents at high risk for ABIM as determined by the risk index that was presented and distributed at the PGY3-to-be Spring Workshop (risk index ≤ 0 after ITE 3).
      c. Participation in a formal board review course will be optional for those residents with a risk index > 0.
         i. The DOM will still pay for a board review course if you want to go
         ii. If you choose not to go to a course, you will have $500 additional funds deposited into your education account to be used to further advance your education in whatever way you believe would benefit you most.
   d. Please contact Drs. Briones or L Ozark with questions.

**Resident Perks**
1. The Department of Medicine (DOM) will purchase MKSAP books for every categorical intern.
2. All categorical interns and residents will have their annual membership to the American College of Physicians (ACP) paid for by the DOM. Membership includes: access to important clinical websites, Annals of Internal Medicine journal, ACP Hospitalist journal, reduced fees for the national conference, and many perks for various online and in-print resources.
3. PGY 2s and 3s receive $500 each year (total of $1000 which can be saved and spent in one lump sum) for educational spending which can include: ACP national conference, additional board review course/materials, or to defray some of the cost for ABIM Board Examination. Educational funds will not be approved if a resident is delinquent on discharge summaries, has not completed their rotation evaluations, or has not attended at least 50% of CPC conferences. If you are considering using educational funds, please contact Steve before you do so since

Updated 6/5/2018
there are specific nuances to reimbursement. Unfortunately, due to the tax law, digital devices (computers, ipads, etc.) cannot be paid for with educational funds. This is the policy of the IRS and not a Loyola policy.

4. The Department of Medicine will pay for any PGY3 to attend a designated Board Review Course held in the spring of the PGY3 year (PGY4 for med-peds). There are additional specifications; please see the section above titled “Board Review.”

5. A resident can also apply for supporting funds if they will be presenting their research at a national conference. Please see the research section above or contact the research Chief Resident.

Retreats

- **Intern Retreat**
  - This required annual event is held during the end of January/early February.
  - All interns are excused from clinical responsibilities starting Friday afternoon until Monday morning to attend (exclusive of Sunday NF).
  - For the past twelve years, we have held this retreat at the beautiful Grand Geneva Resort and Spa in Lake Geneva, WI.
  - Activities include large and small group discussions and workshops about the Profession of Medicine and how to maintain the enthusiasm that called you to medicine in the first place. Camaraderie is developed during time included for reflection and relaxation.
  - Key faculty attend and spouses are welcome.
  - The resort hosts many amenities including a full service spa, ski slopes, horseback riding, and fitness center.
  - Don’t forget the Annual Interns vs Attendings basketball game!
  - Cocktail hour, formal dinner and dancing takes place Saturday night. This weekend is one of the Intern Year highlights!

- **PGY 2 Retreat**
  - We hold a PGY-2 retreat each summer at Irons Oaks Environmental Learning Center in Olympia Fields in early August.
  - The day focuses on developing leadership skills, discussing how to be an effective senior resident, and building camaraderie among our second year residents.
  - Applying for Step 3 will also be covered at this session.

- **PGY 3-to-be Workshop**
  - The Department of Medicine hosts a PGY 3-to-be Workshop annually at the Brookfield Zoo!
  - This session is held in May for the current PGY2s (rising to PGY 3s) and Med/Peds PGY 3s (rising to PGY4s).
  - Topics include: Transitioning into your final year of residency, Residents as Teachers, Preparing for Board Examinations, Licensure, CV and cover letter preparation, Professionalism, Leadership, and Planning for your future career after residency (fellowship or job).
  - Applications for fellowship programs start in June, so this retreat is timed perfectly to allow our second years to have “Just-In-Time” information.
Parties and Other Functions

There are lots of social events designed at building resident camaraderie in and outside of the hospital, below are just a few. Dates will be shared as these events are finalized. Check the CR Friday email for upcoming events

1. Firm Events during the +1 week
2. Chief Resident / Intern outing
3. Summer Kickball Game
4. Intern Appreciation Dinner
5. Fellowship Match Lunch
6. Holiday Party
7. Resident Research Day
8. Senior Week and 'skip day'
9. Graduation

Moonlighting

- Moonlighting is any additional professional activity outside of the training program. A resident who participates in moonlighting must have prior written permission from the Program Director and/or Chair of the Department of Medicine.
- The schedule of these activities should not in any way interfere with the trainee’s performance in the residency program.
- All hours spent moonlighting must be counted as part of the total hours worked per week and may not violate duty hours regulations.

Incident Reporting

- Resident reporting of incidents is of great importance and helps the system self-monitor.
- Residents can help by reporting not only adverse events but also ‘near misses’ (where no patient was harmed, but harm could have happened).
- We have a very supportive department called the “Patient Safety” office at Loyola who are available 24/7.
  - They should be involved early and would rather know about any potential issue early rather than later.
- Reporting near misses helps us all learn about our system's weaknesses before they lead to bad outcomes.

At Loyola:

- Should you witness a significant harm event, you should report it immediately to your attending and to the Risk Manager on call (listed in Web on Call) who is also called “Patient Safety Manager”.
- They will be able to assist you in handling the event and aftermath.
- All the incidents and near misses can be reported through the VOICE system found on the LUMC Portal under the link “Patient Safety Reporting”.
- When reporting an incident please keep your narrative to a minimum, stating only factual information as this information can be ‘discoverable’ in any lawsuit down the road (this should not keep anyone from reporting any patient safety concerns or incidents, however).
- Please do not list opinions and extra information.
- You will be contacted for any clarification needed.
At Hines:

- All incidents and near misses can be reported through the EPER system. The link for this can be found on the Hines VA desktops.
- Additionally, you should notify your senior resident, attending and fellow as well as the Hines Chief Resident.

**Needlestick or exposure to blood/bodily fluids**

If you are exposed to blood or other body fluids while at work, it's important to seek treatment quickly. After washing the area, page 11079 (24/7) for further instructions on next steps – this is true both at Loyola and at the VA. You should also notify your team and the charge nurse.

Generally you will be referred to Occupational Health (during business hours) or the Emergency Department (off-hours and weekends/holidays). However, as it gets complicated depending on when and where you are, the pager above is designed to keep it simple.

If the paging system is down or you do not receive a callback:

1. Business hours: call 6-3156
2. All other hours: call 6-0333 (Vocera) and state "nursing supervisor"

**How to Resolve an Issue**

Ultimately, we want our residents to feel comfortable in our program and to grow in their ability to care for patients and pursue professional goals. If a situation arises with a particular issue of concern, residents have many options available to them. The Chief Residents are a good first step to resolve any issue. In addition, the Program Director (Dr. Simpson for IM or Dr. Nate Derhammer for MP) or any of the APDs can help. The Housestaff Committee (see description above) is made up of residents and each class has their own “voice” on the committee. Finally, if additional concerns remain, the GME office can be a useful resource for the residents. Please refer to Section III of the GME Housestaff Handbook for additional Grievance Policy information [https://www.loyolamedicine.org/gme/current-housestaff](https://www.loyolamedicine.org/gme/current-housestaff)

Additional mean of providing feedback include New Innovations evaluations, including "on-the-fly" evaluations and submitting a VOICE or EPER report.

**Housestaff Representative Committee**

- This vital committee is made up of the Firm Chiefs, 2 preliminary interns, 1 clinical base year neurology intern and 1 med-peds resident from each level in addition to future chief residents for the following academic year.
- Nominations are sought and elections are held in July
- This committee meets bi-monthly starting in August to discuss any housestaff related issues.
- The committee has been directly responsible for many positive changes within the residency curriculum, service structure, and call scheduling.
- You are encouraged to speak with a housestaff representative about any concerns you would like addressed at any time.
- Meetings are open to all housestaff. You may find the representative names and meeting dates on our website [https://www.loyolamedicine.org/gme/internal-medicine-residency/resident-resources/committees](https://www.loyolamedicine.org/gme/internal-medicine-residency/resident-resources/committees)
Service Opportunities

In the Jesuit tradition of service and education, we encourage all Loyola Medicine Housestaff to participate in Community Outreach. Below are some organized ways to become involved in caring for the underserved.

Community Health Clinic
Residents have the opportunity to volunteer with Loyola faculty and chief residents at the Community Health Clinic in West Town (Chicago). This clinic is a volunteer-based clinic serving the uninsured and underserved in Chicago and surrounding communities. Residents serve as preceptors for Loyola medical students to provide primary care services including acute care visits, health consuming and educations and chronic disease management. Clinics take place on Monday evenings throughout the year.

Catholic Charities Health Fairs
Residents have the opportunity to volunteer to provide health screening and assessments at local Catholic Charities Health Fairs held throughout the Chicagoland area on designated weekends during the summer. In this setting, residents work with Loyola faculty and staff as well as medical students. Signs will be posted with dates and emails sent seeking resident volunteers at these events. You are encouraged to participate as your schedule allows.

P.A.D.S (Public Action to Deliver Shelter) Clinic
Residents volunteer weekly at the Oak Park P.A.D.S clinic to provide routine health assessment and acute care services to this patient population. Residents also have the opportunity to interact with nursing and medical students in this setting to develop history taking and exam skills. Please contact the Chief Resident if you are interested, and look for emails regarding this opportunity as the colder months approach.

Immersion Trips/ Global Health

Our novel Global Health Program offers a comprehensive program with curricula and experiences ultimately leading to a GME certificate in “Community and Global Health.” This program is available for PGY 2s and 3s. Applications are generally submitted in May. Please see the very detailed program requirements on the GME Website for full details: https://www.loyolamedicine.org/gme/global-health

Helpful Information while at Hines

Below is the contact information for people who can help you with any problems that might arise while rotating at Hines VA:

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>PERSON WHO CAN HELP</th>
<th>EMAIL ADDRESS</th>
<th>PAGER</th>
<th>EXTENSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer problems/access</td>
<td>LaWanda Rucker</td>
<td><a href="mailto:lawanda.rucker@va.gov">lawanda.rucker@va.gov</a></td>
<td>708/718-1753</td>
<td>24564</td>
</tr>
<tr>
<td>Discharge Summaries</td>
<td>Edna Freeman</td>
<td><a href="mailto:edna.freeman@va.gov">edna.freeman@va.gov</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Supplies/On Call</td>
<td>Becky Alcala</td>
<td><a href="mailto:becky.alcala@va.gov">becky.alcala@va.gov</a></td>
<td>708/718-1749</td>
<td>22140</td>
</tr>
<tr>
<td>corrections/ Room Reservations</td>
<td>Kevin Pohlmann</td>
<td><a href="mailto:kevin.pohlmann@va.gov">kevin.pohlmann@va.gov</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Medicine Problems</td>
<td>Dr. Bruce Guay</td>
<td><a href="mailto:bruce.guay@va.gov">bruce.guay@va.gov</a></td>
<td>708/718-1749</td>
<td>25300</td>
</tr>
<tr>
<td></td>
<td>Dr. Amit Dayal</td>
<td><a href="mailto:amit.dayal@va.gov">amit.dayal@va.gov</a></td>
<td>708/988-0255</td>
<td></td>
</tr>
<tr>
<td>Outpatient Medicine Problems</td>
<td>Dr. Bryan Gee</td>
<td><a href="mailto:bryan.gee@va.gov">bryan.gee@va.gov</a></td>
<td>708/988-0602</td>
<td></td>
</tr>
</tbody>
</table>
Dress Code/Appearance

As a resident, you represent the Department of Medicine. It is expected that our residents will dress professionally at all times (e.g. business/casual clothes, ties, no plunging necklines). Please note, in general, skirt length at work should not exceed 3 inches above the knee.

- Scrubs should be worn only when on call/night float overnight or in the ICU and may *never* be worn to clinic. In addition, it is hospital policy that when wearing the misty green colored scrubs, a white coat must be worn over the scrubs when outside the unit. Additionally, you may *not* wear misty green scrubs outside the hospital. Medicine residents should only wear charcoal grey scrubs and not the surgical misty green, which are meant *only* for the OR/procedure rooms. There are scrubs available in the medicine 6th floor call room for you use via the Scrub-X machine (grey). You may bring them back to the hospital to be exchanged for a fresh pair.

- Open toe shoes are *never* permitted while in patient care areas as it is an OSHA violation.

- Your hospital-issued nametag must always be on and visible.

- White coats should be clean from stains, and your red name plate should be on your pocket. This identifies you as a resident physician. Attending name plates are black and medical school name plates are blue. All categorical residents are given two white coats at the start of the intern year. Preliminary interns are given one white coat. If your white coat needs to be replaced, the Department of Medicine will provide one new coat, upon request, during your PGY2 and PGY3 years (for a total of four white coats). All requests are made through Paulette Campos. A preliminary intern can also have a second white coat upon request.

- At no time should jeans, yoga pants, stretch pants, spandex, etc. be worn when you have patient care responsibilities (this includes weekends).

- If you have any specific questions, please contact one of the Chief Residents for clarification.

Uber/Taxi Reimbursement

If you are ever too tired to drive home safely from Loyola after a long in-house call or a lengthy shift, all residents are encouraged to use an Uber or Taxi to get home safely (and back to work the next day). Please submit receipts to the GME office (Jory Eaton) for reimbursement. Please also note that this is intended exclusively for fatigue safety and should NOT be used for personal trips, car trouble, etc.

Preliminary Year Trainees applying for PGY 2 Positions

Background:

- There is no ERAS/NRMP application for PGY 2 categorical IM positions.

- A trainee is not allowed to successfully complete a Preliminary Year of IM training and then repeat a second PGY 1 year of training.

- Hence, a preliminary year trainee wishing to complete a full 3-year Categorical IM residency must apply, outside of the match, for open PGY 2 IM positions.

1. Process of Securing a **PGY 2 Categorical IM position - Internally**:

- It is the responsibility of the trainee to communicate his/her desire to be considered for a PGY 2 position to the residency Program Director.

- The trainee should strive to excel in all rotations, receiving positive feedback from all attendings, peer residents, and other evaluators.
The Clinical Competency Committee (CCC) will review all evaluations and other feedback with the goal of determining by the 10th of December whether or not to recommend to the program director that a given trainee be offered the opportunity to convert to categorical status.

To be offered this opportunity, evaluations must suggest that the trainee is on a trajectory predicting that he/she would be able to successfully transition into senior resident/PGY 2 responsibilities at the completion of the preliminary year of training.

The Program Director must then secure approval from the Loyola Graduate Medical Education Committee for conversion to categorical status and make the appropriate adjustment to that year’s NRMP match quotas.

If recommended by the CCC and approved by the GMEC, a written offer to convert to categorical status will be provided to the trainee with an expected 7 day time frame for acceptance/refusal of the offer.

Any adjustments to schedules, including the possibility of initiating continuity clinic will be determined on an individual basis taking into account both resource availability and curricular goals.

In addition, it may be necessary to re-assign a trainee into a different firm when beginning the second year of training.

2. Process of Securing a **PGY 2 Categorical IM position - Externally**:

- It is the responsibility of the trainee to communicate his/her desire to be considered for a PGY 2 position to the residency Program Director.
- The trainee should strive to do well on all rotations and receive feedback from all attendings, peer residents, and other evaluators indicating that the trainee is on a trajectory predicting that he/she would be able to successfully transition into senior resident/PGY 2 responsibilities at the completion of the preliminary year of training.
- The trainee should identify appropriate faculty supervisors to request letters of recommendation.
- The trainee should anticipate emailing residency Program Directors at other institutions at regular intervals inquiring as to the likelihood of anticipating an opening for a PGY 2 senior residency position for the upcoming academic year.
- The trainee must inform the Chief Residents immediately upon offers to interview so that appropriate patient care responsibilities may be adequately addressed. While the residency program will make every effort to adjust schedules to facilitate resident availability to interview, ultimately responsibility for assuring appropriate patient care rests with the trainee.
- The trainee must complete the full contract of his/her PGY 1 year of training. It is not possible to terminate the PGY 1 contract early to allow participation in orientation and/or moving/relocation to the new program.

3. Process of Securing a **NON-Internal Medicine position**:

- It is the responsibility of the trainee to communicate his/her desire to apply through ERAS for a non-IM residency position to the residency Program Director.
- The trainee should identify appropriate faculty supervisors to request letters of recommendation.
- The trainee must inform the Chief Residents immediately upon offers to interview so that appropriate patient care responsibilities may be adequately addressed. While the residency program will make every effort to adjust schedules to facilitate resident availability to interview, ultimately responsibility for assuring appropriate patient care rests with the trainee.
- The trainee must complete the full contract of his/her PGY 1 year of training. It is not possible to terminate the PGY 1 contract early to allow participation in orientation and/or moving/relocation to the new program.
Supervision of Residents

The following Supervision Policy is required per ACGME rules and can be found below. The purpose of this detailed document is to allow complete transparency as to who is responsible for the oversight of trainees at every level. Please become familiar with this essential information.

All residents in the Department of Medicine are supervised in a graded fashion according to level of training and abilities. The specific details with respect to individual rotations can be found below:

1. Ambulatory Clinic

All categorical residents are assigned to their own Continuity Clinic at one of three locations. Each clinic is supervised directly by an attending physician, and all patients are staffed with this attending at the time of care.

**PGY1:** All patients are staffed with the assigned supervising attending after they are seen by the intern. The attending then provides direct supervision of this visit by interviewing and examining that patient with the intern.

**PGY2,3:** All patients are staffed with the assigned attending in clinic after being seen by the resident. Residents are supervised in a graded fashion with the patient either being seen by the attending, or having the plan discussed in detail and executed by the resident. This is dependent on the complexity of the complaint and the experience of the resident.

2. General Medicine Inpatient Rotations

The ward-based general medicine rotations at Loyola and Hines VA Hospitals follow the same supervision policy.

**PGY1:** All patients on the team are assigned to an individual intern who will follow that patient throughout their admission. Direct supervision of the intern is by the senior resident assigned to that service who is immediately available. Direct supervision consists of repeating initial intake history and physical, reviewing documentation, checking orders, discussing assessment and plan, and supervising discharge plans/documentation. There is a dedicated attending physician assigned to that team and he/she is responsible for the care of each patient. Direct supervision of the PGY 1 by the supervising attending occurs through daily rounding with the team, interviewing and examining patients assigned, and discussing and approving plans for that patient. Both the attending and PGY 2/3 reads the documentation of the PGY1 and provides feedback.

**PGY 2/3:** Direct and indirect supervision of the PGY 2/3 resident is provided by the attending. Direct supervision takes place during daily rounding. The supervising attending is available via telephone to discuss new patients admitted after rounds or to answer questions that arise regarding current patients. The attending is immediately available via page and if not physically present in the hospital (ie in clinic), available to return to re-evaluate the patient or see new patients. In the case of an unstable patient, a rapid response may be called and the patient will be evaluated by a critical care fellow and immediately triaged for a higher level of care if needed. During evening/overnight hours, PGY1s are directly supervised by PGY 2/3s. An attending physician is immediately available via phone to staff all patients and to answer any questions if needed. Direct supervision is available via the nocturnal hospitalist if needed for an unstable patient.

**Transitions of care:** during evening hours, each patient is “Signed out” by the daytime PGY1 to the nightfloat PGY1 at Loyola and to the Nocturnal Medical Officer on Duty (MOD) at Hines VA (who is a BC/BE attending or fellow). The formal hand-off document is reviewed with the senior resident and checked for accuracy. The PGY 1 then has a face-to-face discussion about each patient on the team with the overnight PGY 1/MOD which includes diagnosis, medications, code status, active issues, and any anticipated problems along with outstanding tests that need to be followed. An opportunity to ask questions and clarify details is given. During the morning transition of care back to the primary team, this document is returned to the PGY 1 and any overnight issues are discussed. This sign-out process is directly supervised by the PGY 2/3 for the first 2-3 months of intern year, and then continued, if needed for complex patients.

3. Cardiology, Hepatology, Hematology, Oncology, Congestive Heart Failure Inpatient Rotations

These ward-based rotations take place at Loyola

**PGY1:** All patients on the team are assigned to an individual intern who will follow that patient throughout their admission. Direct supervision of the intern is by the senior resident and fellow assigned to that service. The senior resident is immediately available at all times, and the fellow is either immediately available in person or via phone/page when they are in clinic. Direct supervision consists of repeating initial intake history and physical, reviewing documentation,
checking orders, discussing assessment and plan, and supervising discharge plans/documentation. There is a dedicated specialist attending physician assigned to that team and he/she is responsible for the care of each patient. Direct supervision of the PGY 1 by the fellow and supervising attending occurs through daily rounding with the team, interviewing and examining patients assigned, and discussing and approving plans for that patient. Both the attending and PGY 2/3 reads the documentation of the PGY 1 and provides feedback.

**PGY 2/3:** Direct and indirect supervision of the PGY 2/3 resident is provided by the fellow assigned to the team and the attending. Direct supervision takes place during daily rounding and throughout the day. The fellow and supervising attending are either immediately available in person or via telephone to discuss new patients admitted after rounds or to answer questions that arise regarding current patients. In the case of an unstable patient, a rapid response may be called and the patient will be evaluated by a critical care fellow and immediately triaged for a higher level of care if needed. During evening/overnight hours, PGY 1s are directly supervised by PGY 2/3s. A fellow or attending physician is immediately available via phone to staff all patients and to answer any questions if needed. The assigned attending or fellow’s name can be found online (AMION) or by calling the hospital operator. All new patients need to be staffed with either the patient’s primary attending (oncology only) or the attending on call. Unstable patients can be seen immediately by a critical care fellow or attending during overnight hours though a rapid response.

**Transitions of Care:** During evening hours, each patient is “signed out” by the daytime PGY 1 to the nightfloat PGY 1. The formal hand-off document is reviewed with the senior resident and checked for accuracy. The PGY 1 then has a face-to-face discussion about each patient on the team with the overnight PGY 1 which includes diagnosis, medications, code status, active issues, and any anticipated problems along with outstanding tests that need to be followed. An opportunity to ask questions and clarify details is given. During the morning transition of care back to the primary team, this document is returned to the daytime PGY 1 and any overnight issues are discussed. This sign-out process is directly supervised by the PGY 2/3 for the first 2-3 months of intern year, and then continued, if needed for complex patients.

4. **Medical Intensive Care Unit and Cardiac Care Unit**

These rotations take place at Loyola

During daytime hours critical care faculty provide direct supervision or indirect supervision with direct supervision immediately available. Both the MICU and the CCU have dedicated fellows who are physically present in the unit. Faculty make rounds daily and discuss management plans with the team. After making rounds, the attending and fellow are within the hospital and immediately available to provide direct supervision. PGY 2/3 residents also provide direct supervision of the PGY 1s during the daytime and review documentation and orders. During the night time hours, there is either an attending or fellow physically present in the hospital and immediately available to provide direct supervision. Residents discuss all admissions within one hour of presentation to the ICU with the assigned fellow on call. PGY 2/3 provide direct supervision of the PGY 1.

**Transitions of Care:**

During the evening, a formal sign-out takes place with both outgoing PGY 1, 2/3 and incoming PGY 1,2/3 present. A formal hand-off document is reviewed and each patient is discussed face-to-face regarding diagnosis, medications and pressors, ventilator settings (if applicable), code status, active issues, and any anticipated problems along with outstanding tests/studies that need to be followed or performed. An opportunity to ask questions and clarify details is given. During the morning transition of care back to the primary team, the PGY 1 and PGY 2/3 again meet to review overnight events and discuss new patients who were admitted.

5. **Bone Marrow Transplant Unit**

The BMTU is a PGY 2/3 rotation. Direct supervision is provided by the fellow and attending assigned to that unit. During the daytime house, direct supervision is immediately available by either the fellow or attending.

During the night time hours, indirect supervision is provided by the assigned unit attending or fellow via phone/page. Immediate direct supervision available by the in-house critical care fellow for emergencies. Residents discuss all admissions within one hour of presentation to the ICU with the assigned fellow on call.

**Transitions of Care:**

During the evening, a formal sign-out takes place with the outgoing PGY 2/3 and incoming PGY 1,2/3 present. A formal hand-off document is reviewed and each patient is discussed face-to-face regarding diagnosis, medications and pressors, ventilator settings (if applicable), code status, active issues, and any anticipated problems along with outstanding tests/studies that need to be followed or performed. An opportunity to ask questions and clarify details is given. During
the morning transition of care back to the primary team, the PGY 1 and PGY 2/3 again meet to review overnight events and discuss new patients who were admitted.

6. Cardiology Hines VA
The patients on the Cardiology Service at the Hines VA are a mix of ICU patients and step-down patients. This team is also responsible for any cardiology consults that take place. Each team is composed of two PGY 2 residents, a fellow, and an attending. During the daytime hours, there is direct supervision of the PGY 2/3 by the assigned fellow and attending who are immediately available. Faculty make rounds daily and discuss management plans. Consult patients are staffed with the fellow within 2 hours of being seen and then seen on rounds with the attending where examination takes place and management is further discussed.

Transitions of Care:
During the evening, a formal sign-out takes place with the PGY 2/3 giving report to the evening/overnight PGY 1 and supervising 2/3 present. The formal hand-off document is reviewed and each patient is discussed face-to-face regarding diagnosis, medications and pressors, ventilator settings (if applicable), code status, active issues, and any anticipated problems along with outstanding tests/studies that need to be followed or performed. An opportunity to ask questions and clarify details is given. During the morning transition of care back to the primary team, the PGY 2/3 reviews overnight events with the outgoing PGY 1 and PGY 2/3 and discuss new patients who were admitted.

6. Medical Intensive Care Unit at Hines VA
During daytime hours critical care faculty provide direct supervision or indirect supervision with direct supervision immediately available. The MICU has a dedicated fellow who is physically present in the unit. Faculty make rounds daily and discuss management plans with the team. After making rounds, the attending and fellow are within the hospital and immediately available to provide direct supervision. PGY 2/3 residents also provide direct supervision of the PGY 1s during the daytime and review documentation and orders. New patients are seen by the PGY 2/3 along with the PGY 1 and staffed with the fellow either in-person, or via phone within one hour of being seen. During the night time hours, indirect supervision is provided with direct supervision available by the fellow. The fellow is available to provide direct supervision if needed. Residents discuss all admissions within one hour of presentation to the ICU with the assigned fellow on call. The assigned fellow and attending on call is available on the Board in the ICU, or online via CPRS, or through the hospital operator. PGY 2/3 provide direct supervision of the PGY 1. If immediate supervision is needed, there is a BC/BE moonlighting attending/fellow Medical Officer on Duty (MOD) present in house who can assist in an emergency.

Transitions of Care:
During the evening, a formal sign-out takes place with both outgoing PGY 1, 2/3 and incoming PGY 1,2/3 present. A formal hand-off document is reviewed and each patient is discussed face-to-face regarding diagnosis, medications and pressors, ventilator settings (if applicable), code status, active issues, and any anticipated problems along with outstanding tests/studies that need to be followed or performed. An opportunity to ask questions and clarify details is given. During the morning transition of care back to the primary team, the PGY 1 and PGY 2/3 again meet to review overnight events and discuss new patients who were admitted.

7. Combined Hematology/Oncology Service
This is a ward-based rotation at Hines VA
PGY1: All patients on the team are assigned to an individual intern who will follow that patient throughout their admission. Direct supervision of the intern is by the senior resident and fellow assigned to that service. The senior resident is immediately available at all times, and the fellow is either immediately available in person or via phone/page when they are in clinic. Direct supervision consists of repeating initial intake history and physical, reviewing documentation, checking orders, discussing assessment and plan, and supervising discharge plans/documentation. There is a dedicated specialist attending physician assigned to that team and he/she is responsible for the care of each patient. Direct supervision of the PGY 1 by the fellow and supervising attending occurs through daily rounding with the team, interviewing and examining patients assigned, and discussing and approving plans for that patient. Both the attending and PGY 2/3 reads the documentation of the PGY1 and provides feedback.
PGY 2/3: Direct and indirect supervision of the PGY 2/3 resident is provided by the fellow assigned to the team and the attending. Direct supervision takes place during daily rounding and throughout the day. The fellow and supervising
attending are either immediately available in person or via telephone to discuss new patients admitted after rounds or to answer questions that arise regarding current patients. In the case of an unstable patient, a rapid response may be called and the patient will be evaluated by a critical care fellow and immediately triaged for a higher level of care if needed. During evening/overnight hours, PGY1s are directly supervised by PGY 2/3s. A fellow or attending physician is immediately available via phone to staff all patients and to answer any questions if needed. The assigned attending or fellow’s name can be found online (CPRS) or by calling the hospital operator. All new patients need to be staffed with the fellow on call.

**Transitions of care:** during evening hours, each patient is “signed out” by the daytime PGY1 to the nightfloat PGY1. The formal hand-off document is reviewed with the senior resident and checked for accuracy. The PGY 1 then has a face-to-face discussion about each patient on the team with the overnight PGY 1 which includes diagnosis, medications, code status, active issues, and any anticipated problems along with outstanding tests that need to be followed. An opportunity to ask questions and clarify details is given. During the morning transition of care back to the primary team, this document is returned to the daytime PGY 1 and any overnight issues are discussed. This sign-out process is directly supervised by the PGY 2/3 for the first 2-3 months of intern year, and then continued, if needed for complex patients.

8. **Consult rotations**
All PGY 1,2,3 who rotate on a consultation service staff the patient directly with the fellow or attending on service.
Rounds take place where additional direct supervision takes place. These consult rotations include: endocrine, infectious disease, rheumatology, cardiology, oncology, hematology, nephrology.

9. **Emergency Medicine**
PGY 1,2,3 rotate at either Hines VA or Loyola.
All interns and residents receive direct supervision by the attending emergency medicine attending who is physically present and immediately available to answer questions, evaluate a patient, or assist with a procedure.

10. **Procedure Supervision**
PGY 1,2,3 track their procedures in the New Innovations procedure log and need to complete a specified number of procedures (according to procedure type) under direct supervision of an attending, fellow, or ‘signed-off’ resident before they can perform that procedure under indirect supervision. For any given procedure, there is an attending who is ultimately responsible for that procedure and can be called to assist if needed. This request can be called by the resident, the supervising nurse, or any staff member in the procedure. Additionally, if a resident attempts a procedure three times without success, a supervisor needs to be called to assist.

Procedures and number of directly observed procedures required (as determined by the ABIM) is listed below:
- Arterial Blood Gas (ABG) Draw (5)
- Arthrocentesis (5)
- Central Venous Line Placement (5)
- Central Venous Line Removal (3)
- Incision and drainage of an abscess (3)
- Intra-osseous line placement (3)
- Lumbar Puncture (5)
- Nasogastric Intubation (3)
- Pap Smear and Endocervical Culture (5)
- Paracentesis (5)
- Peripheral Venous Line Placement (3)
- Peripheral Venous Blood Draw (3)
- Thoracentesis (5)

We hope you have found this document useful and would like any feedback you have about other topics to include. Any specific questions can be directed to any of the Chief Residents or APDs/PD. This document will be updated in the digital copy as needed. The date in the footer section will reflect any updates.