

**University of Michigan Health System
Internal Medicine Residency**

**General Medicine Curriculum - Inpatient Wards
(Newburgh, UH Medicine, Ann Arbor VA Wards, Night Float)
University of Michigan Medical Center and
Ann Arbor Veterans Administration Medical Center**

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Rotation Goals and Educational Purpose

Internists are essential providers of comprehensive care for hospitalized patients. These rotations therefore provide necessary exposure to common medical problems of hospitalized patients. Inpatient ward rotations also provide opportunities for residents to refine history and physical exam skills, form diagnostic plans, and manage a wide variety of diseases. Additionally, hospital wards allow residents to encounter uncommon medical conditions and directly interact with subspecialists while managing patients with complex conditions.

Ann Arbor VA and University Hospital rotations are mandatory for residents at the HO1/2/3 levels. Newburgh and Night Float rotations are mandatory for HO2/3 residents.

Rotation Competency Objectives

Selected from the University of Michigan Longitudinal Learning Objectives, the following provide an overview of the knowledge, skills, and behaviors promoted in these hospital medicine rotations.

- I. Medical Knowledge and Patient Care
 - a. Core Knowledge:
 - i. HO1 residents will
 1. demonstrate satisfactory knowledge of common medical conditions, sufficient to manage urgent complaints under supervision;
 2. by completion of HO1, exhibit sufficient knowledge to provide care for common medical conditions with minimal direct supervision;
 - ii. HO2 residents will in addition
 1. demonstrate progression in knowledge of pathophysiology and clinical biosciences as necessary to develop appropriate differential diagnoses and diagnostic plans for complex multi-problem patients;
 2. demonstrate correct interpretation of basic biostatistical principles, including sensitivity, specificity, predictive values, likelihood ratios, number needed to treat, odds ratios, and statistical significance;

- iii. HO3 residents will additionally reflect maturing knowledge of the breadth of internal medicine, with ability to address content across the generalist and subspecialist spectrum.
- b. History taking
 - i. HO1 residents will consistently gather accurate and relevant historical and emotional information, organize the information according to medical convention, and chart it in a timely and efficient manner. By completion of HO1, histories will be hypothesis driven; residents will use history gathering as an opportunity to create a patient-focused care environment.
 - ii. HO2 and HO3 residents will in addition efficiently collect complex historical information from written, electronic, and oral sources. Collected information will be accurate, verified, and prioritized. Residents at this level will demonstrate ability to integrate accurate collected information into succinct historical narratives that inform and prioritize both differential diagnoses and diagnostic plans.
- c. Physical Examination
 - i. HO1 residents will identify normal from abnormal and elicit critical findings using common examination maneuvers.
 - ii. HO2 residents, in addition, will correctly detect subtle findings. They will teach appropriate physical exam skills to junior learners.
 - iii. HO3 residents, in addition, will understand the sensitivity and specificity of maneuvers.
- d. Clinical Judgment
 - i. HO1 residents will
 - 1. develop prioritized differential diagnoses, diagnostic plans, and therapeutic plans for common inpatient and ambulatory conditions;
 - 2. correctly identify acute conditions requiring urgent intervention;
 - 3. recognize when patient presentations deviate from common patterns, requiring supervisory assistance for complex decision making; and
 - 4. under supervision, assess and respond to recommendations derived from consulting services and requests from referring healthcare services, integrating prior data with current clinical assessments to generate appropriate diagnostic and therapeutic plans.
 - ii. HO2 residents will, in addition,
 - 1. demonstrate recognition of the performance characteristics of commonly used diagnostic tests, incorporating appropriate clinical judgment to make diagnostic decisions in the setting of imperfect data;
 - 2. regularly incorporate consideration of risks and benefits when considering diagnostic tests and therapies;
 - 3. independently generate diagnostic and therapeutic plans for all acute and chronic care settings; and
 - 4. by completion of HO2, demonstrate ability to manage urgent care needs with minimal supervision.
 - iii. By completion of HO3, residents will in addition
 - 1. demonstrate appropriate reasoning in ambiguous situations, interfacing evidence based medicine with expanded clinical judgment to guide efficient diagnostic and clinical plans;
 - 2. rapidly and independently diagnose and manage common urgent conditions;
 - 3. disseminate diagnostic and management skills to junior trainees, modeling appropriate clinical judgment and effective decision-making;

4. consistently establish monitoring procedures and demonstrate ability to change therapeutic plans for ineffectiveness or adverse side effects; and
 5. Practice quality palliative care, and provide information on palliative and/or hospice care opportunities for patients for whom that may be a preferred option.
- e. Procedures
- i. HO1 residents will demonstrate knowledge of procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care. They will participate in informed consent, assist patients with decision making, and attend to patient comfort.
 - ii. HO2 residents will additionally demonstrate extensive knowledge and be facile in the performance of procedures while minimizing risk and discomfort to patients. They will assist junior peers in skill acquisition.
- f. Health Promotion and Disease Prevention
- i. HO2 residents will effectively engage patients in behavioral and clinical care discussions. They will counsel patients about health-affecting behaviors, medical tests and treatments. They will recommend screening exams as appropriate for patients' needs.
 - ii. HO3 residents, additionally, will consistently partner with all patients and their families to promote health. They will treat all patient encounters as opportunities for health promotion and disease prevention education. They will demonstrate effective secondary and tertiary prevention skills necessary for effective chronic care management. They will recognize limitations of guidelines in application to individual patient needs, and will adjust their recommendations appropriately.

II. Interpersonal and Communication Skills

- a. Communication with patients and families
- i. HO1 residents will
 1. establish rapport with patients from a variety of backgrounds;
 2. elicit patient-centered and physician-centered information necessary to inform an accurate medical and social history;
 3. engage patients or their advocates in therapeutic relationships that support shared decision making for uncomplicated diagnostic and therapeutic decisions;
 4. participate effectively in family meetings, demonstrating active listening skills for topics such as end of life care;
 5. exhibit nonverbal communication skills that enhance physician-patient interactions.
 - ii. HO2 residents will in addition
 1. under guidance, engage patients in shared decision making for ambiguous or controversial scenarios;
 2. under supervision, compassionately communicate serious diagnostic or prognostic information to patients and families;
 3. under supervision, lead communication during family meetings;
 4. engage patients and their families or advocates in decisions in the end of life setting including discussions regarding options for care;
 5. demonstrate expanding skill in communication across the cultural spectrum; and
 6. successfully negotiate most "difficult" patient encounters, such as the irate patient.

- iii. HO3 residents will in addition
 - 1. with minimal direction, engage patients in shared decision making for ambiguous or controversial scenarios;
 - 2. successfully engage in shared decision making in multi-cultural contexts;
 - 3. successfully negotiate nearly all “difficult” patient encounters with minimal direction; and
 - 4. with minimal supervision and acting as a role model for junior learners, compassionately communicate with patients and families regarding sensitive topics, including serious diagnostic and prognostic findings and end-of-life care options.
- b. Communication with physicians, other health professionals, and health related agencies; interpersonal function as a member or leader of a health care team
 - i. HO1 residents will, by completion of HO1,
 - 1. deliver appropriately succinct oral presentations of patients’ histories, physical examinations, laboratory data, assessments, and plans. Presentations will be hypothesis-driven, synthesizing knowledge for accurate transmission; they will be adjusted in length and format to situations ranging from brief conversations with colleagues to formal presentations at conferences. Presentations will include prioritized differential diagnoses, assessment of chronic problems, and hypothesis-driven diagnostic and therapeutic plans for each active problem;
 - 2. use succinct oral communication effectively with senior residents, attending physicians, and ancillary staff to facilitate coordination of patient care;
 - 3. pose clear queries to consulting services;
 - 4. provide complete oral and written patient hand-offs;
 - 5. form effective partnerships with nursing and other allied health professionals to facilitate patient care; and
 - 6. under supervision, participate in communication with primary care referring physicians.
 - ii. HO2 residents will in addition
 - 1. facilitate communication between team members, including establishing expectations, overseeing patient care, ensuring participation in academic discussions, providing feedback to learners, etc; and
 - 2. ensure continuity of patient care through effective inpatient-outpatient provider communication.
 - iii. HO3 residents will in addition
 - 1. communicate effectively as a team leader, with decreasing reliance upon faculty physicians; and
 - 2. model and teach inter-professional communication skills for junior learners.
- c. Communication as a consultant to other physicians and health professionals
 - i. All residents will communicate their role as a consultant to the patient, identifying and supporting the primary care relationship. Under faculty supervision, they will accurately identify referring physician concerns and questions, and direct accurate and complete written documentation of consultative care back to the referring physician. Residents will demonstrate appropriate consultative general medicine care for patients primarily cared for by non-medical services.
- d. Written communication
 - i. HO1 residents will
 - 1. create thorough and accurate hand written or electronic documentation that is legible, timely and congruent with medical standards;

2. avoid use of disallowed or confusing abbreviations and nonstandard terms;
 3. accurately maintain electronic patient lists including problem lists, medication lists, and allergy lists; and
 4. interact with electronic medical records to create succinct, relevant, and accurate patient-specific notes.
- ii. HO2/3 residents will in addition use electronic documentation as a tool for improved patient care. They will endeavor to produce concise documentation, emphasizing clarity and accuracy of the written record.

III. Professionalism

a. Personal Professionalism

- i. HO1 residents will demonstrate a personal commitment to
 1. Honesty, integrity, and trustworthiness;
 2. Recognizing mistakes and notifying the supervising attending when mistakes are made;
 3. Self-care and self-preservation, including attention to duty hour limits, appropriate personal rest, and appropriate public health and infectious disease precautions;
 4. Personal accountability for daily clinical responsibilities;
 5. Recognizing the scope of one's personal capacity, including limits of duty volume and personal stress; and
 6. Seeking and accepting assistance from colleagues and supervisors for duties that exceed personal ability or capacity.
- ii. HO2 residents will additionally demonstrate a commitment to personal professional excellence by
 1. Promoting and facilitating personal responsibility behaviors for junior learners, emphasizing honesty, integrity, trustworthiness, and recognition of personal limits;
 2. Demonstrating and promoting timeliness in task completion, punctuality, and dependability; and
- iii. HO3 residents will additionally
 1. Demonstrate personal professional leadership by reflecting upon the above objectives in ethically or personally complex settings which challenge personal integrity and require reflective self assessment.

b. Physician-patient professionalism

- i. HO1 residents will demonstrate
 1. Appropriate grooming, attire, and demeanor;
 2. Commitment to provision of quality care for patients of all cultures, beliefs, and values;
 3. Empathy and compassion toward all patients;
 4. Recognition of physician-patient behavioral boundaries, including the unethical nature of sexual contact between physicians and current patients;
 5. Commitment to relief of pain and suffering;
 6. Respect for the personal dignity of patients, including respect personal privacy during physical examination;
 7. Maintenance of patient confidentiality; and
 8. Timely, open, and honest communication with patients and their designated advocates.
- ii. HO2 residents will additionally demonstrate

1. Compassionate response to issues of culture, age, sex, sexual orientation, and disability in patient care;
 2. Recognition and management of conflicts of interest (e.g. gifts, caring for close others) and understanding the moral/ethical considerations with respect to the patient
 3. Primary concern for the patient's needs, consistent with a fiduciary relationship;
 4. Compassionate care for dying patients and their families; and
 5. Respect for informed consent as a shared decision making process.
- iii. HO3 residents will additionally demonstrate
1. Advocacy and appropriate surrogate identification for patients who lack decision-making capacity;
 2. Counseling of patients regarding testing implications prior to ordering genetic tests, or referral to another provider qualified to provide full discussion;
 3. Under supervision, timely and full disclosure of medical error;
 4. Commitment to provision of physical, psychological, social and spiritual support for dying patients and their families, including high quality palliative and hospice care; and
 5. Leadership of compassionate team care that respects patient dignity and autonomy.
- iv. Professional behaviors among colleagues
1. All residents will
 - a. Recognize that physicians have a responsibility for the safety and well-being of colleagues and staff;
 - b. Treat colleague physicians and allied health professionals with respect through professionally appropriate communication that acknowledges the potential for professional differences of opinion;
 - c. Demonstrate respect for colleagues through attention to timely response to pages, emails, duty hours logging, electronic chart completion, dictations, etc.

IV. Practice-Based Learning and Improvement

- a. identify strengths, deficiencies, and limits in one's knowledge and expertise; set learning and improvement goals; identify and perform appropriate learning activities; and incorporate formative evaluation feedback into daily practice:
 - i. HO1 residents will
 1. understand personal limitations, ask for help when needed, and admit to medical errors;
 2. seek and accept formative feedback;
 3. independently explore curricular resources available to enhance skills in areas of relative weakness;
 4. use consulting services to improve self-knowledge, appropriately integrating expert consulting opinion based on personal learning activities and independent reading; and
 5. deliver care that demonstrates learning from previous experiences.
 - ii. HO2 /3 residents will additionally
 1. voluntarily seek supervised learning opportunities for knowledge and procedures not yet mastered; and

2. demonstrate continual identification of personal learning opportunities, recognizing that all patient care interactions present opportunities for case-based learning and improvement.
- b. locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; use information technology to optimize learning
 - i. HO1 residents will
 1. demonstrate self motivation to acquire new knowledge; and
 2. access University clinical resources, library resources, and web-based resources to locate evidence necessary to support patient-centered decision-making.
 - ii. HO2 residents will additionally
 1. independently and voluntarily use Pubmed or Ovid to locate scientific evidence necessary to enhance patient care;
 2. with assistance, appraise and assimilate scientific literature; and
 3. demonstrate understanding and use of evidence-based medicine principles in providing patient care.
 - iii. HO3 residents will additionally
 1. independently apply knowledge of study design and statistics to critical appraisal of relevant literature in clinical settings; and
 2. reflect understanding of the limits of protocol and guideline-derived management, incorporating patient-centered shared decision making with applicability of care evidence.
- c. participate in the education of patients, families, students, residents and other health professionals
 - i. HO1 residents will
 1. facilitate learning of medical students and peers; and
 2. participate in education of patients and families through provision of accurate and appropriate information.
 - ii. HO2/3 residents will additionally
 1. facilitate education of other health care professionals, using interactions with other professionals as two-way educational opportunities; and
 2. treat consultation services as opportunities for shared education between physicians.

V. Systems-Based Practice

- a. work effectively in various health care delivery settings and systems, and coordinate patient care within the health care system,
 - i. HO1 residents will
 1. work well within a core clinical team of physicians, nurses, and allied health professionals involved in the direct care of their patients; and
 2. reflect awareness of social service resources.
 - ii. HO2 residents will additionally
 1. coordinate multi-specialty care;
 2. appropriately consult social workers and case managers for current patient care needs;
 3. understand roles and services provided by sub-acute rehabilitation, hospice, home care, and nursing facilities; and
 4. effectively work with allied professionals in team settings such as family meetings and multidisciplinary rounds.
 - iii. HO3 residents will additionally

1. strive to provide leadership in management of complex multi-disciplinary care plans, acting as a team leader during interdisciplinary family meetings;
 2. manage care and care transitions across multiple delivery systems, including ambulatory, subacute, acute, LTACH, rehabilitation, and skilled nursing settings.
- b. incorporate considerations of cost awareness and risk-benefit analysis in patient and population-based care
- i. HO1 residents will incorporate fundamental cost-effective considerations into care approaches, minimizing unnecessary care and unnecessary delays of care;
 - ii. HO2 residents will additionally
 1. understand the principles of DRG payment;
 2. demonstrate understanding of insurance systems, including Medicaid, Medicare, and local insurance options;
 3. demonstrate awareness of drug costs, reflecting commitment to provision of cost effective therapy; and
 4. demonstrate awareness of common ambulatory medical care delivery systems, including visiting nurse care, ambulatory rehabilitation resources, social services, home hospice, and transportation services, as alternatives to hospitalization.
 - iii. HO3 residents will additionally
 1. appropriately contain costs and conserve limited resources while preserving high quality care;
 2. proactively consider potential continuing care needs at all stages of acute medical management; and
 3. appropriately utilize all alternate levels of care for maximal value and quality of care.
- c. advocate for quality patient care and optimal patient care systems; work in interprofessional teams to enhance patient safety and improve patient care quality; and participate in identifying system errors and implementing potential systems solutions
- i. HO1 residents will
 1. demonstrate dedication to high quality patient care; and
 2. demonstrate willingness to identify both system errors and potential solutions for the purpose of enhancing patient safety and quality of care.
 - ii. HO2 residents will additionally
 1. access and implement services designed to provide quality care to high risk populations, including substance abuse treatment services and social work referrals;
 2. demonstrate ability to effectively guide continuity patients through complex health care systems;
 3. demonstrate awareness of healthcare disparities limiting quality of patient care across populations; and
 - iii. HO3 residents will additionally
 1. partner with case managers and other providers to identify and act on improvement opportunities for the health system;
 2. recognize and appropriately refer patient safety concerns including at risk elderly, disabled and intimate partner violence, guardianship services, DPOA, and involuntary mental health needs; and
 3. identify and appropriately refer patients for home services.

Teaching Methods

I. Supervised Patient Care

- a. This curriculum, including Goals and Objectives, is reviewed at the start of the rotation.
- b. The emphasis of this rotation is on experiential learning through supervised management of hospitalized patients. Residents perform admission and continuing care evaluations under full supervision of a faculty internist. Faculty discussions review each patient daily. Night Float rotating residents present newly admitted patients to the Medicine Faculty Hospitalist (MFH) supervising physicians.
- c. Patients present from a broad range of ages, geographic area, and socioeconomic backgrounds. Residents interact with complex systems of care, including a broad range of medical and nonmedical physician services, allied professional services (e.g. nursing, respiratory therapy, physical therapy) and administrative staff throughout these rotations.
- d. Procedures may be performed as medically indicated. All procedures are fully supervised until established minimum experience is demonstrated.

II. Structured Didactics and Small Group Learning

- a. Morning Report – weekdays at 10:30 – 11:30 AM. Small group discussion. Case presentations are led by the chief medical resident for interactive learning, with faculty facilitation. Core content, including patient safety, is emphasized.
- b. Journal Club – Once monthly, during Morning Report. Landmark historical articles and current articles are reviewed, as selected by the Chief Resident. Faculty are present to facilitate discussion.
- c. Intern Report – Tuesdays 12:30-1:30PM. Didactic presentations by chief residents, incorporating interactive discussion. Sessions are led by the Chief Medical Resident to review core biomedical content for common presenting complaints. Diagnosis, initial triage management, and patient safety are emphasized. Presentation archives are available for individual review on the residency curriculum website.
- d. Noon Conference – M/W noon – 1PM. Didactic presentations by faculty. Topics are selected and organized by the chief medical residents in order to review central clinical topics. Presentation archives are available for individual review on the residency curriculum website.
- e. Board Review – Thursdays noon – 1PM from January – June only. Content is selected from the American College of Physicians Medical Knowledge Self Assessment Program (MKSAP). Led by the Chief Resident, faculty experts are present to facilitate.
- f. Grand Rounds/Morbidity and Mortality – Fridays at noon. Invited speakers and U of M faculty provide insights into the state of the art on diverse topics, spanning from basic science research to social justice. At least twice monthly, the session is devoted to Morbidity and Mortality rounds, with interactive clinical discussion designed to improved clinical care and patient safety.
- g. Attending Rounds – Daily at 7:30 – 10:30 AM. Faculty review each patient and provide integrated education and feedback regarding patient-centered content and clinical decision making. Evidence-based management is emphasized during integrated teaching/management rounds. Additional teaching content may be scheduled by the attending in the afternoon (check with the faculty).
- h. Chief Rounds – Fridays 9-10 AM, attended by the University Hospital ward general medicine on-call teams. The Chair of the University of Michigan Department of Internal Medicine or a designee meets with these teams for bedside patient-centered education. The long call team presents a case, and the short-call team is present for discussion.

- III.** Special projects - Morning Report and Intern Report case presentations are performed by residents. Each presenting resident prepares teaching content for their peers, including identification of take-home learning points. The Chief Residents distribute presentation assignments to maximize opportunities for all residents during the training year.
- IV.** Independent study
- a. Textbooks, manuals, and general reference. Free access provided by the Taubman Medical Library unless otherwise noted.
 - i. Access Medicine – This high-yield compendium of resources includes a “quick answers” section for common clinical conditions; the “Diagnosaurus” diagnosis tool; information on common diagnostic tests; and numerous textbooks. Access via <http://www.accessmedicine.com/features.aspx> or from <http://www.lib.umich.edu/hsl/resources/medicine/>
 - ii. ACP PIER – the American College of Physicians Information and Education Resource is a decision-support tool for point-of-care evidence-based medicine. Diagnosis and treatment are emphasized, common clinical decisions are clearly addressed, and level of evidence is stated. Access available at <http://www.lib.umich.edu/hsl/resources/medicine/>
 - iii. Harrison’s Principles of Internal Medicine (latest edition)
 - iv. Mettler: Essentials of Radiology (latest edition). Access available at <http://www.mdconsult.com/das/book/body/110985731-3/0/1276/0.html>
 - v. UpToDate – Topic reviews written by invited authors. Access available at <http://www.lib.umich.edu/hsl/resources/medicine/>
 - b. Clinical practice guidelines
 - i. The National Guideline Clearinghouse is an initiative of the Agency for Healthcare Research and Quality (AHRQ) and provides clinical guidelines that meet inclusion criteria, along with syntheses of selected guidelines on common topics, and expert commentary. Access is open to the public at <http://www.guideline.gov/>
 - c. Hospital medicine website: Society of Hospital Medicine (SHM) access at: <http://www.hospitalmedicine.org/>
 - d. Online multimedia learning
 - i. Chest radiograph interpretation is reviewed in an interactive tutorial by Dr. Eric Bensadoun and Tom Dolan of the University of Kentucky at: <http://www.mc.uky.edu/education/images/flash/chestnew.swf>
 - ii. Introduction to Chest Radiology from the University of Virginia includes instructions for basic interpretation, many examples of abnormal findings, and a self study quiz: <http://www.med-ed.virginia.edu/courses/rad/cxr/>
 - iii. “Central Venous Catheterization: Techniques to Reduce Complications” Davoren Chick, University of Michigan. Interns must complete this through MLearning. MLearning is accessible through the residency curriculum: <http://www.med.umich.edu/intmed/resident/info/curriculum.htm>. Access the assigned course through “My Learning Plan” or search for course code OCAX-20082 to enroll.
 - iv. Acid-base tutorial - <http://www.acid-base.com/>. Alan W. Grogono, Tulane University Department of Anesthesiology. This site is highly recommended for all. Peer-reviewed, light-hearted, and interactive.
 - v. ECG Wave Maven, developed by Nathanson LA, McClennen S, Safran C, and Goldberger AL, Beth Israel Deaconess Medical Center: <http://ecg.bidmc.harvard.edu/maven/mavenmain.asp>

- vi. ECG Learning Center by Dr. Yanowitz from the University of Utah provides didactic content and self-study quizzes:
<http://library.med.utah.edu/kw/ecg/index.html>
- vii. Cardiac Examination/Heart Sounds tutorials: <http://www.blaufus.com/>
- viii. “CT is us,” Dr. Elliott Fishman at Johns Hopkins University has posted an excellent CT tutorial for multiple organ systems: <http://www.ctisus.com/organsys/index.html>
- ix. HO3 residents should complete module #4 “Inpatient Coding” of Coding 101, which addresses inpatient, observation, and discharge coding:
<http://sitemaker.umich.edu/coding101>

Rotation Schedule

First day protocol: Interns switch roles one week prior to residents. Interns and HO2/3 residents should obtain oral and written transfer of patient care from the appropriate prior team member prior to the start of the rotation. Incoming residents should contact current interns regarding their expectations for daily care.

Call duty: Interns are assigned call overnight Q4. HO2/3 complete call at 9 PM after transferring care to the Night Float resident, whose shift is 8 PM – 7 AM. Night float should then provide oral and written return transfer of care to the oncoming team prior to departure.

Weekend duty: Residents will have an average of one day off in 7 over the course of a 4-week rotation block. The day off is determined based on the call schedule, and may or may not occur on a weekend. There is no short call on the weekend.

Continuity Clinic: General medicine continuity clinic continues during this rotation, one half-day weekly, with adjustments or to the schedule as necessitated by residency program guidelines.

	Monday	Tuesday	Wednesday	Thursday	Friday	Sat/Sun
AM	7:00 Preround 7:30 Attending Rounds 10:30 Morning Report	7:00 Preround 7:30 Attending Rounds 10:30 Morning Report	7:00 Preround 7:30 Attending Rounds 10:30 Morning Report	7:00 Preround 7:30 Attending Rounds 10:30 Morning Report	7:00 Preround 7:30 Attending Rounds 9:00 Chief Rounds – UH on call only 10:30 Morning Report	7:00 Preround 7:30 Attending Rounds
PM	12:00 Noon Conference [2:00 Faculty Rounds, variable] 5 pm Sign out 8 PM Night Float HO2/3 care transition	12:30 Intern Report [2:00 Faculty Rounds, variable] 5 pm Sign out 8 PM Night Float HO2/3 care transition	12:00 Noon Conference [2:00 Faculty Rounds, variable] 5 pm Sign out 8 PM Night Float HO2/3 care transition	12:00 Board Review (Jan-June only) [2:00 Faculty Rounds, variable] 5 pm Sign out 8 PM Night Float HO2/3 care transition	12:00 Grand Rounds/M&M 5 pm Sign out 8 PM Night Float HO2/3 care transition	5 pm Sign out 8 PM Night Float HO2/3 care transition

Evaluation Methods

Formative face-to-face feedback to residents by attendings occurs at mid-month. Each month, attendings complete online competency-based evaluations of each resident. The evaluation is shared with the resident, is available for on-line review by the resident at his/her convenience, and is sent to the residency office for internal review. The evaluation is part of the resident file and is incorporated into semiannual performance reviews for directed resident feedback. Residents also complete a service evaluation of the rotation faculty monthly.