Duke Department of Medicine
Duke University School of Medicine

Faculty Orientation Guide

October 2013

This document was prepared and reviewed by the following faculty and staff:

Laura P. Svetkey, MD
Vice Chair for Faculty Development and Diversity

Kimberley Evans, MD
Chair: Minority Recruitment & Retention Committee

Susan Gurley, MD
Chair: Program for Women in Internal Medicine

Mary E. Klotman, MD
Chair, Department of Medicine

Martha Adams, MD; Cathleen Colon-Emeric, MD; Michael Gunn, MD;
Monica Kraft, MD; David Simel, MD; Lalit Verma, MD; Aimee Zaas, MD;

Jennifer Averitt, Cindy Johnson, LaVerne Johnson-Pruden, Larrita Long,
Gregory Mavraganis, Elizabeth McCamic, Jasmine-Symone Pruden,
Donna Salvo, Jarrett Spence and Anton Zuiker

Version date: October 2013

Table of Contents

Chapter 1: Personal Information

Getting Started

In addition to this Department of Medicine (DoM) orientation package, you may want to visit the Medical Center Library website for new faculty: http://guides.mclibrary.duke.edu/content.php?pid=45306&sid=390173

Private Diagnostic Clinic (PDC)

Most physicians who join the DoM become members of the Private Diagnostic Clinic (PDC). The PDC has an orientation program called "On-boarding"; information can be found at https://intranet.dm.duke.edu/ent/pdc/SitePages/Physician%20Integration.aspx. In addition, we have included some PDC information in this and other chapters.

PDC Contact:

Physician Integration, Associate Director
Donna Ecclestone, (o) 919-419-5057, (c) 919-943-0375

To learn more about PDC orientation, visit one of these web pages:

PDC intranet site:
https://intranet.dm.duke.edu/ent/pdc/SitePages/Home.aspx

Public website:
http://medicalstaffrecruitment.duke.edu/modules/msr_boarding/index.php?id=2

Key information provided by your Division Administrator (DA):

1. Your address, mailbox, and email
2. How to obtain office keys
3. How to obtain an ID badge – take a requisition from the DA to the Services Center on the basement level of the Duke Clinics near the Medical Center Bookstore.
4. How to get a lab coat – take a requisition from the DA to the Medical Center Bookstore on the basement level of the Duke Clinics near the Services Center.
5. How to set-up the computer desktop – coordinated by the DA with Department of Medicine IT support staff*

Parking – you must register your vehicle and pay for parking at the Services Center on the basement level of the Duke Clinics. http://www.parking.duke.edu/forms_apps/index.php

Required Visit to Employee Health – call (919) 684-3136 for an appointment, or walk-in. The location is the ground floor, Duke Clinics, across from the Red Zone Elevators. http://www.hr.duke.edu/about/departments/eohw/placement.php

Note these requirements for faculty with patient contact:

- Substance Abuse Screening
- Tuberculosis screening
- Immunity Status
- Color Blind Screen
- Hepatitis B vaccination
- Respiratory Clearance Health Form
- Respiratory fit testing

Duke@Work

work.duke.edu

You will want to come back to this website, a portal that allows one-stop editing and review of your professional profile, a review of your research portfolio, your benefits and University pay. The section for "MyResearch" is especially useful, a toolbox of required research forms, project management, and budget reports.
Be sure to review your personal and demographic information to be sure it's accurate!

Benefits

Most MD faculty have an appointment within Duke University and in the Private Diagnostic Clinic and are eligible for benefits from both entities. Some faculty are also eligible for Veterans Administration (VA) benefits. Here are sources for more information:

Duke University

http://www.hr.duke.edu/benefits/
Contact: James Nieman, DoM Human Resources,(919) 684-2524
He is an excellent source of information regarding DU benefits and other HR issues.

Private Diagnostic Clinic (PDC) – more info in Chapter 3

https://intranet.dm.duke.edu/ent/pdc/SitePages/Human%20Resources.aspx
Contact: Joy Sprink, HR Director, PDC, (919) 684-2280.
She is very helpful and will cut through the massive benefits explanation in the PDC Manual.

VA

If you also have a VA appointment, speak to your Division Administrator about getting benefits information.

Your Faculty Appointment

Your appointment letter states your faculty level and your mentorship plan. If you have questions, discuss those with your Division Chief.

For further general information about procedures and requirements for Appointments, Promotion and Tenure (AP&T) see Chapter 8.

Mentoring and Feedback

Mentoring (information and opportunities) should be in your appointment letter. Annual feedback is typically given by Division Chief and as needed. If it's not automatically scheduled in your division, be sure to ask for this annual meeting.

Understanding Duke Information Systems

Each member has dedicated storage space for electronic files on the DoM network. Please review this with your division's IT Support Staff at the time of setting up your desktop computer. Besides being password protected and secure, there is a back-up protocol in case of physical loss. You can access the files remotely, too. If you intend to work from home or while traveling, please discuss remote access with your Division's IT support staff.

Computer security: Portable and removable devices, though often critical to our work, pose a significant security risk, i.e., a risk that sensitive patient information or research data could be acquired by unauthorized individuals. All mobile media (i.e., laptops and "thumb" drives) must be encrypted. Please discuss laptop encryption procedures with your Division's IT support staff. Encrypted thumb drives are available in the Duke Computer Store. We advise encrypting CDs and DVDs just like encrypting thumb drives.

For help with encryption, here are several options:

1) Ask your Division's IT staff
2) Ask the DHTS Helpdesk (919) 684-2243
3) Submit your inquiry via this web form http://www.dunk.duke.edu/secure/submit
4) Explore this web resource: https://www.iso.duke.edu/iso/encryption/index.php

If you work at the VA, be sure you're familiar with IT security rules in the VA system as they differ from DoM rules.

How to Get Help

For Department or Division Computers
For example, your desktop computer
Requests for technical help: IT Service Desk at (919) 684-2243, or
DHTS web form http://www.dunk.duke.edu/secure/submit/

For Clinical PIN Workstations
Computers on the hospital wards and in the clinics are "PIN Workstations".
Requests for technical help: DHTS Helpdesk at (919) 684-2243
Be prepared to give your "unique ID" which is found on the back of your Duke ID badge.

Network Access – Your User ID

As a faculty member you will have two network IDs, one called your "NetID" account that is used to access Duke University resources, and another called your "DHE" account, used to access Medical Center resources. These two accounts will probably have the same username (in years past these were different) and there is a way to ensure that your passwords for the two accounts match. To learn more, follow this link: http://www.oit.duke.edu/email-accounts/netid/index.php

Examples: you will use your NetID account for the following resources:

- Blackboard Learning Management System
- Duke iTunes Classroom archives
- The OIT Website
- Electronic IRB website (eIRB)
- Faculty intranet link from DoM home page (see "DoM Websites" below)

Examples: you will use your DHE account for these resources:

- Your office desktop computer login
- All hospital computer workstations
- MAESTRO/EPIC (Electronic medical record system)
- Your VPN account for remote access
- Wireless Network available in all Duke Medicine buildings (network name: Clubs)

Once you receive clinical credentials, your Division Administrator will obtain your network ID so that you can access the Duke network for clinical information systems.

HIPAA Privacy & Security

Every faculty member has responsibility to ensure confidentiality and integrity of data. This responsibility is particularly critical for protecting patient information. Here are a few critical things to remember:

Duke data may not be stored on non-Duke computers. All data sent outside of the Duke protected network **must be encrypted**. Ask your IT support staff for specific instructions.

The content of e-mail is not secure. E-mail with secure electronic information (SEI) sent outside of the Duke protected network must be sent using the "send secure" feature (SEI button) from Duke's e-mail system.
http://www.chg.duke.edu/security/emailpolicy.html
Shred-it boxes are nearby to your work areas. Use the boxes for discarding documents with any sensitive electronic information.

The following is an example of an acceptable privacy statement for e-mail:

CONFIDENTIALITY NOTICE - This e-mail communication is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any

unauthorized review, use disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by phone and destroy all copies of the e-mail.

The following are two examples of acceptable privacy statements for FAX transmissions:

"This information in this facsimile is sensitive, protected information intended only for the addressee(s). Any other person, including anyone who believes he/she might have received it due to an addressing error, is requested to notify the sender immediately by return electronic mail, and to delete it without further reading or retention. The information is not to be forwarded to or shared unless in compliance with DUHS policies on confidentiality and/or with the approval of the sender."

"This document consists of ____ pages including this cover sheet. If you have any questions or transmission problems, please call the voice number.
THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPY OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY."

Strong passwords are a requirement. Safeguards are in place to monitor these.

For more information referencing federal and state regulations and associated Duke Policies:
http://www.security.duke.edu
http://him.duhs.duke.edu
https://intranet.mc.duke.edu/dhts/iso/SitePages/Home.aspx
https://intranet.dm.duke.edu/compliance/hipaa/SitePages/Home.aspx

Compliance Offices

School of Medicine: http://medschool.duke.edu/research/compliance-office

DUHS: https://intranet.dm.duke.edu/compliance/SitePages/Home.aspx

PDC: https://intranet.dm.duke.edu/ent/pdc/SitePages/Policies%20and%20Procedures.aspx

Wireless Network

The "clubs" wireless network requires set-up with your DHE account. The Helpdesk can respond to your questions: 919-684-2243 or DHTS IT web form http://www.dunk.duke.edu/secure/submit/

Remote Access

Virtual Private Network (VPN) Access: when we are off-campus, Duke provides VPN software for us to connect to the Duke network over the internet (including with Apple iPad). This requires installation of software called "AnyConnect." Download from http://vpn.duhs.duke.edu

For more information about VPN:
http://oit.duke.edu/net-security/network/remote/vpn/index.php

Clinicians can also access "Virtual PIN," the clinical repository (MAESTRO), from this webpage http://awi.duhs.duke.edu
You will find instructions to install software called "Citrix" in order to launch this secure web view of clinical information.

Other Valuable Self-help Web Resources

OIT, the Duke University Office of Information Technology, is a very useful site including site-licensed software. The web site address is: http://www.oit.duke.edu/.

Web Sites for the Department of Medicine and Divisions

Your personal web profile displays within DukeHealth.org (http://www.dukehealth.org) and the Department's public website (http://medicine.duke.edu).

Public pages

http://medicine.duke.edu
These pages represent the department to the public and prospective faculty and trainees. Every Division, Center, and Institute links off of this main site. For questions, contact the DoM Communications Director, Anton Zuiker, anton.zuiker@duke.edu, 919-613-4310.

MedicineNews blog

The MedicineNews blog at http://news.medicine.duke.edu/ is a conduit of news, announcements and links that reflect the activities of the department. Faculty members are encouraged to bookmark the site (consider making it your home page), subscribe to the site's RSS newsfeed, and visit the site regularly. Submit your news via this form, http://news.medicine.duke.edu/submit-news/.

Intranet (non-public) pages

http://domcentral/Pages/DoMCentraldefault.aspx
These pages include our internal news items, recordings of grand rounds, and various FAQ documents, for example, AP&T procedures. You'll be asked to log in to access this site. For questions, contact the DoM Communications Director, Anton Zuiker, anton.zuiker@duke.edu, (919) 613-4310.

Conference Archives Online

Medicine Grand Rounds are delivered each Friday at 8am in Duke University Hospital room 2002 (the auditorium above the hospital's main entrance). Videos from the presentations are posted within a few weeks to the archives on the DOM intranet, http://domcentral/Pages/DoMCentraldefault.aspx

Communications

These are key contact numbers and weblinks to know.

Duke Hospital Operator – (919) 684-8111.

Paging Web – to page someone and to find out who is on call for most clinical services, go to: http://pagingweb.oit.duke.edu/.

Online Phone Book Directory – to find any phone number at Duke, go to http://www.oit.duke.edu/email-accounts/phonebook/index.php

Photos and the Physician Referral Directory (PRD) – this is an annual publication listing clinicians in practice within Duke Medicine. To get a personal photo portrait (PRD covers the cost for clinicians, DOM covers for research faculty), contact Duke Photography, Phone (919) 684-4391. Photos are taken in the studio on the 4th floor, Orange Zone, Duke South, Room #4314.

Note that your photo is used on DukeHealth.org and your faculty profile page on the DOM website.

Director of Communications, Department of Medicine – Anton Zuiker, anton.zuiker@duke.edu, (919) 613-4310

Division network support

Each division has a specified source of network support. Contact network support as noted in the table below.

Contacts:

DIVISION		Net Friends	ACADEMIC	DCCI	HSRD	CHG
Cardiology			X			
Cellular Therapy						
Clinical Pharmacology						
Endocrinology		X				
Gastroenterology			X			
General Medicine					X	
Geriatrics		X				
Hematology						
Infectious Diseases		X				
Medical Genetics						X
Medical Oncology				X		
Nephrology		X				
Neurology		X				
Pulmonary			X			
Rheumatology		X				

Net Friends:

- Endocrinology: support-endo@netfriends.com
- Geriatrics: support-geri@netfriends.com
- Hematology: support-hem@netfriends.com
- Infectious Disease: support-id@netfriends.com
- Nephrology: support-neph@netfriends.com
- Neurology: support-neuro@netfriends.com
- Rheumatology: support-rheum@netfriends.com

Academic IT Support: via DHTS helpdesk *(919) 684-2243* or this web form http://www.dunk.duke.edu/secure/submit
HSRD (GIM): hsrdit@duke.edu
CHG: problem@chg.duhs.duke.edu

Faculty Research Directory: **Scholars@Duke** (https://scholars.duke.edu) - A public directory of Duke School of Medicine and School of Nursing faculty, searchable by keyword, last name, or department.

To view or update your profile and publications, click “log in” in the upper right-hand corner of the screen. You will use your “NetID” and password for access.

These are important pages, not only to share your research interests with future collaborators, but also to have up-to-date information mapped (linked) to public Duke web pages, including DukeHealth.org and your faculty profile page on the DOM website.

In addition, a public resource for learning about research and researchers at all institutions in North Carolina can be found at http://reachnc.org/.

Training and Certification

http://www.safety.duke.edu/
Knowing about safety, equity, and compliance are core competencies for everyone. This site is sponsored by the Occupational and Environmental Safety Office (OESO). Access to the site requires your NetID and Password. Navigate to the modules via the left-hand menu, choosing "On-line Training."

You will see your personal required courses and due date for completion. Each of the modules takes about 15-30 minutes. Here are common modules:

- Respirator Training for Airborne Pathogens
- OSHA Blood borne Pathogens (BBP)
- Tuberculosis (TB) Safety Training
- Fire/Life Safety
- Ergonomics Overview
- General Chemical Safety
- Environment of Care
- Time-out Training Module
- Organ, Tissue &Eye Donation Training
- Infection Control
- Equity at Duke
- Compliance Update Training

Institutional Review Board (IRB) training – If you are involved in any way in human research (including use of stored human samples or data), you also need to complete CITI training modules through the IRB website. Go to http://irb.duhs.duke.edu/. (See also Chapter 4.)

Animal Care and Use Program (IACUC) training - If you are involved in any way in animal research, you will need to complete web-based training modules at http://vetmed.duhs.duke.edu/TrainingOverview.html

Other helpful websites

Public:

http://www.duke.edu

http://medschool.duke.edu

http://www.dukehealth.org

http://www.dukemedicine.org

http://today.duke.edu

http://inside.dukemedicine.org

Intranet (non-public):

http://intranet.dukemedicine.org

Summary of websites in this chapter

Medical Center Library New Faculty Guide: http://guides.mclibrary.duke.edu/content.php?pid=45306&sid=390173

Duke Intranet site: http://intranet.dukemedicine.org

Parking and Transportation: http://www.parking.duke.edu/forms_apps/index.php

Employee Health: http://www.hr.duke.edu/about/departments/eohw/placement.php

Duke@Work: **work.duke.edu**

Duke benefits: http://www.hr.duke.edu/benefits/

PDC benefits: https://intranet.dm.duke.edu/ent/pdc/SitePages/Human%20Resources.aspx

DoM AP&T: https://intranet.medschool.duke.edu/domcentral/doccenter/Documents/Forms/APT.aspx

SoM AP&T: http://medschool.duke.edu/faculty/faculty-apt-office

IT Service Desk: https://www.dunk.duke.edu/secure/submit/index.htm

Remote Access: http://vpn.duhs.duke.edu

Virtual Pin: http://awi.duhs.duke.edu

University Office of Information Technology (OIT): http://www.oit.duke.edu/

Duke Health.Org: http://www.dukehealth.org

Public pages: http://medicine.duke.edu

Intranet (non-public) pages: http://domcentral/Pages/DoMCentraldefault.aspx

Conference Archives Online: https://intranet.medschool.duke.edu/domcentral/SitePages/Home.aspx

Duke iTunes: http://itunes.duke.edu

Paging: http://pagingweb.oit.duke.edu/

Phone directory: http://www.oit.duke.edu/email-accounts/phonebook/index.php

Faculty Research Directory: **Scholars@Duke** (https://scholars.duke.edu)

Public directory of researchers: http://reachnc.org

Safety training: http://www.safety.duke.edu/

IRB: http://irb.duhs.duke.edu/

IACUC training: http://vetmed.duhs.duke.edu/TrainingOverview.html

PDC on-boarding: https://intranet.dm.duke.edu/ent/pdc/SitePages/Physician%20Integration.aspx

Chapter 2: Who's Who

Department of Medicine Executive Board

Last Name	First Name	Responsibilities	Assistant		Phone (919 area code)	Fax (919 area code)
Chair						
Klotman, MD	Mary	Chair, DoM	Salvo	Donna	668-1755	681-5400
Senior Vice Chair						
Coffman, MD	Thomas	Academic Affairs	Hartless	Jamie	684-9708	684-3011
Vice Chairs						
Corey, MD	Ralph	Education and Global Health: Responsible for all aspects of pre- and post-graduate medical education within the department; develop a strategic plan around global health and how that can be further incorporated into DoM training programs.	Bartley	Rhonda	668-7174	668-7059
Doty	Joe	Administration	Williams	Joy	684-3842	681-5400
Palmer, MD	Scott	Research: Facilitate the DoM Research agenda. For example: identify concerns related to research in DoM; seek opportunities for retaining promising investigators; organize a departmental research retreat; develop strategies for increasing utilization of DCRU; re-organize DoM grants administration.	Wilbur	Martha	684-0245	684-5266
Simel, MD	David	Veterans Affairs: Oversee the medical service at the Durham VA. For example, encourage proposals for VA merit review and career development awards; increase student and intern satisfaction during VA rotations; meet or exceed all “VA external monitors” for quality, access and performance.	Long	Larrita	286-6941	286-6873
Svetkey, MD	Laura	Faculty Development/Affairs and Diversity: Promote successful academic development, promote diversity, and address alleged faculty misconduct. For example, implement a	Johnson-Pruden	LaVerne	681-6386	681-5400

		mentoring initiative; provide mock review for career development awards; facilitate submission of diversity supplement applications; develop and oversee a DoM database for tracking faculty composition and AP&T process; facilitate PWIM and MRRC (see below); investigate and advise the Chair when faculty misconduct is alleged.				
Zaas, MD, MHS	David	Clinical Practice: Improve efficiency and quality of the practice. For example, improve productivity of ambulatory care; optimize coding and increase collection rates for clinical revenue; develop provider scorecards for each physician	Bass	Helen	684-7226	684-7124
Associate Vice Chairs						
Evans, MD	Kimberley	Minority Affairs/Chair of Minority Recruitment and Retention Committee (MRRC): Provide programs in support of under-represented minority faculty and fellows. For example: sponsor two visiting professorhsips each year; sponsor attendance at AAMC URM faculty development seminars; facilitate peer mentoring among URM faculty, housestaff, and med students; provide faculty development seminars; assist with minority housestaff recruitment; etc	Johnson-Pruden	LaVerne	681-6386	684-5400
Gurley, MD	Susan	Women's Affairs/Chair of Program for Women in Internal Medicine (PWIM): Provide programs in support of women faculty and fellows. For example, sponsor two visiting professorships each year; sponsor attendance at AAMC women's faculty development seminars; facilitate peer mentoring; provide faculty development seminars; etc.	Johnson-Pruden	LaVerne	681-6386	681-5400
Directors						
Lyles, MD	Kenneth	Site-Based Research: Facilitate clinical research. For example, provide post-award study management services; develop account receivables/revenue management tool for industry-sponsored; develop research operations	Harris	Monica	660-7520	684-8569

		manual; work with Dr. Palmer (see above) to advance the DoM research agenda; etc.				
Ortel, MD	Thomas	Lab-based Research: Facilitate basic science research. For example, develop a plan for optimal allocation and utilization of research space; work with Dr. Palmer (see above) to advance the DoM research agenda; etc.	Cash	Jennifer	684-3355	681-6160
Pisetsky, MD	David	Chair, DoM Appointments, Promotion and Tenure (AP&T) Committee	Boggs	Rita	286-6835	286-6891
Shah.MD	Bimal	Director of Quality Improvement & Credentialing	Loveday	June	668-8596	668-7058
Zaas, MD	Aimee	Director, Residency Program: Oversee house staff training. For example, expand opportunities for housestaff research; mentor residents; facilitate compliance with new ACGME duty hour requirements; incorporate bench marks in the evaluation process; enhance continuity of care in ambulatory settings; develop Quality Improvement projects.	Payne	Erin	681-1464	681-6448
DoM Administration						
Doty	Joe	Vice Chair, Administration	Williams	Joy	684-3842	681-5400
McCamic	Elizabeth	Communications Specialist			613-4310	681-5400
Milton	Barbara	Faculty AP&T			684-6590	668-0726
Morris	Gregory	Information Technology			684-2243	681-7666
Nieman	James	HR Director			684-2524	668-0726
Raymer	Ashley	Credentialing			684-2416	668-0726
Reagan	Janet	Director of Budgets and Finance	Glasgow	Phyllis	684-4659	668-0726
Salvo	Donna	Administrative Manager			668-1755	681-5400
Zuiker	Anton	Director of Communications			613-4310	681-5400
Research Administration						
Jackson	Christina	Associate Director for Post-Award Research Administration			684-0649	684-7599
Torres	Laurianne	Director, Research Administration			684-0676	684-7599
White	DeeDee	Associate Director for Pre-Award Research Administration			668-0721	684-7599

Medical Education						
Alkon	Shawna	Staff Assistant			681-2383	681-6448
Arcasoy, MD	Murat	Associate Program Director, Curriculum, Research & Quality Assessment	Cash	Jenny	684-3355	681-6160
Averitt	Jen	Senior Programs Coordinator			681-4510	681-6448
Butterly, MD	David	Associate Program Director, Recruitment			970-4419	
Cho, MD	Alex	Associate Program Director, Ambulatory			684-6291	
Dincher	Lauren	Scheduling Coordinator			681-2383	681-6448
Gagliardi, MD	Jane	Director, Undergraduate Medical Education (UME)	Gainey	Sheila	681-5258	668-5271
Gainey	Sheila	Program Coordinator, Undergraduate Medical Education (UME)			681-5258	668-5271
Hargett, MD	C. William	Associate Program Director, Fellowship Program			970-0434	
Heffelfinger	Randy	Senior Administrator	Green	Teressa	681-9509	681-9599
Payne	Erin	Program Coordinator, Recruitment			681-1464	681-6448
Rivelli, MD	Sarah	Program Director, Med/Psych			970-3090	
Woods, MD	Suzanne	Program Director, Med/Peds			970-8586	
Zaas, MD	Aimee	Director, Residency Program, Educational Innovations Project (EIP) & Programmatic Support	Payne	Erin	681-1464	681-6448
Other						
DHTS Help Line		IT support (see link below)			684-2243	
Hospital Operator					684-8111	

https://intranet.dm.duke.edu/dhts/coo/supportoperations/acadsupport/SitePages/RequestHelp.aspx

Division Leadership

Division	Division Chief		Assistant		Phone	Fax	Clinical Chief
Cardiology	O'Connor	Christopher	Simpson	Lisa	681-6195	681-7755	Joseph Rogers, MD (681-3398)
Cell Therapy & Hematologic Malignancy	Chao	Nelson	Kajcienski	Jennifer	668-0361	668-1091	Cell Therapy: Gwynn Long, MD (668-1011) Heme Malignancy: David Rizzieri (668-1040)
Endocrinology	Feinglos	Mark	Lunsford	Faye	684-4005	681-8477	Jennifer Perkins , MD (684-3841)
Gastroenterology	Diehl	Anna Mae	Hay	Kathy	684-2366	684-8857	Stan Branch, MD (668-7193)
General Internal Medicine	Boulware	Ebony	Jackson-Goode	Nina	668-7217		Lynn Bowlby, MD (471-8344)
Geriatrics	Schmader	Kenneth	Caudill	Mary	660-7582	684-8569	Heidi White, MD (660-7516)
Hematology	Ortel	Thomas	Cash	Jennifer	684-3355	681-6160	Murat Arcasoy, MD (684-5350)
Hospital Medicine	Gallagher	David	Hester	Jason	668-2496	668-5394	-
HVI	Denny	Thomas	Anderson	Lettie	681-5199	684-5230	-
Infectious Disease	Perfect	John	Harris	Michelle	684-6854	684-8902	Jason Stout, MD (668-0826)
Medical Genetics	Hauser	Elizabeth	Simeonova	Radina	684-0608	684-0934	-
Medical Oncology	Abruzzese	James	Rothwell	Mia	681-9509	681-9599	Louis Diehl, MD (684-8964)
Nephrology	Coffman	Thomas	Hartless	Jamie	684-9788	684-3011	Steve Smith, MD (660-6865)
Palliative Care	Tulsky	James	McCoy	Trish	668-7215	684-0572	
Pulmonary	Kraft	Monica	Terry	Nancy	684-8401	684-8404	Joseph Govert , MD (681-5919)
Rheumatology	St. Clair	William	Pierce	Shadonna	684-4499	684-8358	Megan Clowse, MD (681-2045)

Division	Division Adminstrator		Assistant		Phone	Fax
Cardiology	Kowalski	Joe	Whitaker	Jennifer	668-0202	681-7917
Cell Therapy & Hematologic Malignancy	Tobin	Kathleen	Holder	Carol	668-3747	668-1091
Endocrinology	Plocharczyk	Anthony			684-7113	681-8477
Gastroenterology	O'Neill	Cathy			681-4288	684-8857
General Internal Medicine	Wright	Lisa			681-4653	681-8716
Geriatrics	Caudill	Mary			660-7582	684-8569
Hematology	Wilkins	Linda			684-6184	684-6824
Hospital Medicine	Weissberger	Joanne			668-5541	668-5394
HVI	Lahti	Cheri			668-0937	681-5195
Infectious Disease	Pendergraph	Sandra	Harris	Michelle	684-6854	684-8902
Medical Genetics	Due	Barbara			681-3561	684-0980
Medical Oncology	Heffelfinger	Randy	Green	Teressa	681-9509	681-9599
Nephrology	Tucker	Patsy			668-2366	684-4476
Palliative Care	Wright	Lisa			668-4653	681-8716
Pulmonary	Peterson	Julia			668-4719	684-6985
Rheumatology	Trabert	Mary			684-5546	684-8358

See also: http://medicine.duke.edu/about-department/administration-and-staff

Chapter 3: Clinical Information

Compliance Training

Important: All faculty are required to complete compliance training before receiving training on any clinical information system.

This is an annual requirement. All faculty must view the presentation, complete the quiz, acknowledge receipt of a personal copy of the Code of Conduct, and agree to abide by all of its terms in order to receive credit for the training.

The training is available on-line via the website of the Occupational & Environmental Safety Office (OESO). Click on "On-Line Training" and follow the directions. To access the OESO website, go to: http://www.safety.duke.edu/

These pages on the *Duke Medicine Intranet* provide more information about Compliance and an opportunity for a 30 minute orientation session in the Searle Center (the orientation may be helpful but it is not required). For questions, contact the Compliance Office at (919) 668-2573.

https://intranet.dm.duke.edu/compliance/SitePages/Home.aspx

https://intranet.dm.duke.edu/SitePages/Home.aspx

It's possible to view an online orientation slide presentation also. https://intranet.dm.duke.edu/compliance/SitePages/Orientation%20Information.aspx

For Duke Raleigh Hospital (DRaH) contact Education Services at (919) 954-3489.

On-line Training modules to be completed are located here: http://www.safety.duke.edu/

Clinical Quality Metrics

Duke Hospital participates in public reporting of Center for Medicare/Medicaid Services (CMS) hospital quality measures, for example, timing of antibiotic administration. We are moving towards similar reporting for clinicians; some are already in place. Currently we report to CMS the Physician Quality Reporting Initiative (PQRI) measures. You will need to become familiar with this term. We will also be deploying the "Meaningful Use" objectives, a Federal regulation led by the ARRA/HITECH Act, during 2011 and forward. Both of these are incentive programs to improve patient outcomes and accelerate adoption of the electronic health record. Please work with your Division Clinical Lead to understand these important terms and implications.

Focused Professional Practice Evaluation (FPPE)

As a new clinician you will undergo a FPPE review by a physician colleague and a nurse in your clinic setting within the first 3-6 months of employment. This is a Joint

Commission requirement. FPPE is a process to evaluate your specific competence/performance. For questions, contact your Division Clinical Lead.

Besides national measures critical for reimbursement, your biannual re-credentialing process at Duke depends on documentation of internal quality measures. You will receive an annual report of your status from the Chair's Credentials Office. For re-credentialing questions, contact your Division Clinical Lead.

Maestro Care

Duke's Maestro Care electronic health record creates "one patient, one record, one system" across Duke Medicine.

Everything you need to know about Maestro Care can be found at https://intranet.dm.duke.edu/sites/MaestroCare/SitePages/Home.aspx

Maestro Care is implemented across the entire health system, every point of care – from scheduling an appointment, to examinations, to the pharmacy, to billing – and it is accessible through one integrated system.

Duke's Maestro Care is built on Epic's proven EHR technology.

There are many reasons for implementing a fully integrated EHR. None is more important than the single reason that unifies all others – our core value of "Caring for our patients, their loved ones, and each other," supported by our affiliated values of excellence, teamwork and safety.

You can stay informed about the Maestro Care project and find details about your implementation date and training requirements at https://intranet.dm.duke.edu/sites/MaestroCare/SitePages/Articles/NewsAnnouncements.aspx

Other Useful Online Clinical Resources

Medical Center Library website for new faculty orientation:
http://guides.mclibrary.duke.edu/content.php?pid=45306&sid=390173

List of clinical resources found on the Staff Intranet:
https://intranet.dm.duke.edu/hospitals/duh/SitePages/Clinical%20Resources.aspx

Duke Patient Safety and other Duke links
http://discc.duke.edu/heart_it/duke_webs.htm

Safety Reporting System
https://srs.duhs.duke.edu/Default.aspx

DUHS Clinical Laboratories online lab manual
http://labs.dhe.duke.edu/labman/Test.asp

Portal within the Duke Heart Center:
http://discc.duke.edu/heart_it/

Duke Health Patient Portal
https://healthview.dukehealth.org/wps/portal

Common Terms at Duke

PACS – Centricity: An electronic "file room" that allows online viewing of radiologic images.
http://pacsinfo.dhts.duke.edu/modules/whatispacs/index.php?id=1

Web based training available on the Learning Management Systems:
http://www.hr.duke.edu/training/location/lms/

One or two days after completing training you will receive an email communication from the Help Desk with your system ID and password.

Net Access: This is the primary computer system used at Durham Regional Hospital. For Net Access training contact the DRH medical staff services office (919-470-6254). Access is granted upon completion of training.

Summary of websites in this chapter

Online Compliance Training: http://www.safety.duke.edu/

Orientation information: https://intranet.dm.duke.edu/compliance/SitePages/Orientation%20Information.aspx

Training for Clinical Systems:
https://intranet.dm.duke.edu/hospitals/duh/SitePages/Clinical%20Resources.aspx

CareDoc: http://cis.dhts.duke.edu/modules/cis_hed/index.php?id=1

Durham Regional Hospital Credentialing Information:
http://guides.mclibrary.duke.edu/content.php?pid=45306&sid=334852

PACS – the Picture Archive and Communications System:
http://pacsinfo.dhts.duke.edu/modules/whatispacs/index.php?id=1

Duke Clinical Information Systems: http://cis.dhts.duke.edu

Intranet resources: https://intranet.dm.duke.edu/SitePages/Home.aspx

Virtual PIN: http://awi.duhs.duke.edu

eBrowser
Information: http://clinapp1.duhs.duke.edu/eBrowserHelp/eBrowserPageFrames.htm

Learning Management System: http://www.hr.duke.edu/training/location/lms/

Medical Center Library website for new faculty orientation:
http://guides.mclibrary.duke.edu/content.php?pid=45306&sid=390173

List of clinical resources found on the Staff Intranet:
https://intranet.dm.duke.edu/hospitals/duh/SitePages/Clinical%20Resources.aspx

Duke Links
http://discc.duke.edu/heart_it/duke_webs.htm

Safety Reporting System
https://srs.duhs.duke.edu/Default.aspx

The Duke Heart Center Portal
http://discc.duke.edu/heart_it/

DUHS Clinical Laboratories online lab manual
http://labs.dhe.duke.edu/labman/Test.asp

Duke Health Patient Portal
https://healthview.dukehealth.org/wps/portal

MAESTRO
https://intranet.dm.duke.edu/sites/maestrocare/SitePages/Home.aspx

Chapter 4: Research Related Information and Resources

If you are a basic, translational, or clinical researcher, you will be continuously developing research ideas and applying for research funding. Your overall research portfolio is likely to be composed of several different research projects, each funded separately. The development of fundable research projects is a skill that will be critical to your success as an independent researcher. Here, we have outlined the steps required to develop and obtain funding for your research projects, along with some suggestions and resources that have been developed to assist you in this process.

N.B. This information is intended to *supplement* (not replace) scientific mentoring that you set up with the help of your Division Chief, and grants management processes set up by your Division Administrator. Be sure to also get their input as you develop your research plans and grant applications.

> The National Institute of Allergy and Infectious Disease (NIAID) has a very good web site (http://www.niaid.nih.gov/researchfunding/grant/strategy) that discusses the overall process of obtaining funding. The emphasis is on NIH funding, but their suggestions are broadly applicable.

Step 1 – Identify an appropriate funding mechanism

Possible funding mechanisms include NIH and foundation awards and industry-sponsored research. NIH funding is preferred by your department, so familiarize yourself with the specific NIH award mechanisms that are suited to your career stage. The NIH offers two basic types of awards: *solicited* and *unsolicited*. For solicited awards, the NIH publishes Funding Opportunity Announcements (FOAs) describing the specific research topic that they are interested in. These include both Requests for Applications (RFAs), which are typically one-time opportunities with dedicated money, and Program Announcements (PAs), which are more general. If your work fits well into a specific RFA, this will be your best opportunity to get funded, since you will compete only with other applicants for the RFA in a dedicated study section. PA applicants typically compete with unsolicited award applicants in the standing study sections, but receive a slight scoring advantage. For unsolicited awards, the most common application type, you will suggest the specific topic of your research to the NIH and compete with similar proposals in one of the standing NIH Study Sections.

You will want to stay abreast of all funding opportunities that are applicable to your research. Several databases and mailing lists exist to help you do this:

Research Opportunity Databases

- **Funding Opportunities** (http://researchfunding.mc.duke.edu) – Duke's Funding Opportunities website.
- **NIH OER webpage** (http://grants1.nih.gov/grants/guide/index.html) – A listing of all active NIH RFAs and PAs. Importantly this can be searched by keyword. A list of

all active NIH RFAs, sorted by institute, can be found here. A list of all active NIH PAs, sorted by institute, can be found here.

- **Grants.gov** (http://www.grants.gov/applicants/find_grant_opportunities.jsp) – Grant opportunities from 26 federal grant-making agencies.
- **COS Pivot** (http://pivot.cos.com/profiles/main) - A database of funding opportunities, searchable by keyword. Click on the "Funding" tab. See the Pivot Getting Started Guide.

Research Opportunity Mailing Lists

- **Duke Funding Alert Newsletter** – a weekly listing of foundation and NIH FOAs. Subscribe here.
- **NIH Guide LISTSERV** - a weekly listing of NIH FOAs. Subscribe here.
- **DoM Research Development News** – includes a weekly listing of foundation and NIH FOAs tailored for Duke basic and translational scientists. To join, email resdev@duke.edu with "Subscribe" in the subject line.

The Duke Office of Research Support (ORS) also provides training in methods and resources available for identifying specific funding opportunities. Contact: Judith Andersson, Outreach Coordinator/Funding Specialist, 919-681-8925, Email: judith.andersson@duke.edu Office: 700 Erwin Square Plaza

Step 2 – Identify advisors and potential collaborators

Duke offers you the advantage of being a highly collaborative institution. You will want to take advantage of this. This will include identifying mentors for your overall career, a topic covered in Chapter 8. This will also include identifying investigators that can advise, assist, and possibly collaborate with you on specific research projects. We strongly advise you to find such people. Investigators who attempt to "go it alone" typically do not do well. Fortunately, there are a number of resources available to help you identify people at Duke with expertise in a given research area.

How to find investigators at Duke with expertise in a specific area

- **Scholars@Duke** (https://scholars.duke.edu) - A public directory of Duke School of Medicine and School of Nursing faculty, searchable by keyword, last name, or department.
- **COS Pivot** (http://pivot.cos.com/profiles/main) - A database of all researchers at Duke University, searchable by keyword. Click on the "Profiles" tab. See the Pivot Getting Started Guide.
- **NIH RePORTer** (http://projectreporter.nih.gov) – A database of NIH-funded research grants. Search by Organization (ie Duke) and keyword. It will show you what has been funded in your area.

Step 3 – Identify research resources

Duke University offers more than 30 state-of-the-art shared research facilities that are available for use by all Duke investigators. These Core Facilities will perform specific research tasks, typically on a fee-for-service basis. Core facilities are physically housed and administered by Duke research institutes and centers. In some cases, there is more than one core facility that performs a specific task, so you may want to fully explore your options and ask others about to get the lowdown on a specific core.

- **SoM Core Facilities -** (http://medschool.duke.edu/research/core-research-facilities) - A listing of Duke School of Medicine Core Facilities. Be aware that some of the core names can be a little cryptic, so you may need to do some hunting for what you want.
- **Biostats support for investigators** – DoM initiative with the Department of Biostatistics & Bioinformatics to provide biostatistics services to DoM investigators.

Step 4 – Develop your research plan

Once you have identified a funding mechanism to apply for and tentatively identified the people and facilities you will be working with, you will need to develop a research proposal. Typically, this will involve formulating a research plan based on your preliminary data, your specific hypotheses, and what you wish to accomplish. We strongly recommend that you begin formulating your research plan early, at least 4 months before your grant deadline, by outlining your preliminary data, hypotheses and proposed studies. Do this before you start grant writing. Review this outline with experienced investigators who have expertise in your area of research or have been on the study section that is likely to review your proposal. This will help you identify any problems with your approach or gaps in your preliminary data or proposed methodology while there is still time to make changes.

To facilitate the development of your research plan, the **DoM Research Development Council (RDC)** offers "concept reviews" for proposed grants. In these reviews, you present your background, preliminary data, and tentative research plan to a group of experienced investigators. The group will provide you with feedback, identify potential problems, and offer you suggestions as to how the research plan may be improved. This may include identifying potential collaborators or methods that may enhance your proposal. We strongly recommend that you take advantage of this internal review mechanism. The RDC has a record of significantly improving proposals, even those of experienced investigators. To arrange a concept review or discuss the details of this mechanism, email resdev@duke.edu with your request.

Step 5 – Write your grant application

Once your research plan is fully developed, you will write your grant application. If you are a new investigator, be aware that writing a major NIH grant, such as an R01, is not like anything you have done before. It needs to be great to be competitive. You will need to start writing several months before your submission deadline if you want to do it right. Trying to write grants at the last minute is the biggest mistake that investigators

make. You will need time to craft, review, and get feedback on every aspect of your proposal. Fortunately, there are a number of mechanisms available at Duke to help you in this process. We strongly recommend that you take the general grant-writing course at your first opportunity. This will provide you with many of the skills that you will need. There are several other programs to guide you through the development and writing of your grant. Take advantage of these.

Grant-writing courses, seminars, and training

- **Gopen Writing Seminars** – This annual seminar series focuses on scientific writing from the reader's perspective. Sessions are typically held in October/November.
- **Write Winning Grants** – This 1-day grant-writing workshop provides in-depth advice for writing a successful grant proposal and is usually held in July. Take this. Period.
- **Path to Independence Program** - Faculty mentoring initiative designed to assist junior investigators in securing their first independent R01 funding.
- **K club** - A program designed to help junior faculty prepare career development (K) grant applications.
- **DoM Research Development Council** – For grant-writers at any level. Even established investigators can benefit. See info above.
- **Additional information -** Please see Chapter 8 for information on DoM initiatives to facilitate career development awards and diversity supplement awards.

.

Step 6 – Submit your grant application

Work closely with your division's grant administrator to make sure everything is done correctly and on time. Review the budget carefully! The administrative parts of a grant (budget, justification, key personnel, biosketches, etc) need to be reviewed internally before submission to a funding agency – this can take time! But you can submit the administrative sections before you finalize the scientific sections.

Grants Management

How grants & contracts structure works

- **Pre-Award Process:** The **Office of Research Administration** (ORA), previously called Grants & Contracts, is responsible for supporting investigators and administrators in the School of Medicine and the School of Nursing by managing externally sponsored research projects through the pre-award process.

- As you prepare and submit your grant, there are two processes to consider: the development of your scientific questions, which you will do with your mentor, and

the actual submission of the grant to the funding agency. This section will focus upon the latter.

- **Submission process:** The Department of Medicine (DoM) has a **grants administrative group** and many divisions have grants support personnel. The DoM or Division grants support personnel will help you with the grant submission process, including helping you with your budget (making sure salaries, F&A, directs/indirects, etc. are correct); putting your budget, budget justification and abstract into the electronic system and submitting to Duke ORA for approval; and helping with the final submission to the funding agency. The DoM grants office or your divisional grants administrator will also help you with post-award-related issues (expenditure reports, progress reports, etc.)

- **Exceptions:** There are a few exceptions for faculty in the Department of Medicine, for example the Duke Clinical Research Institute, the Center for Human Genetics, and Institute for Genome Sciences and Policy, have their own grants administrators. If you are a joint faculty at one of these Centers/Institutes, you may want to use those resources, depending on where your post-grant funding will be administered. Discuss this decision with your Division Chief.

- **Contacts:** Office of Research Administration (ORA) at Duke (aka Grants & Contracts) http://research.som.duke.edu/
  The ORA Director will be the signing official for your grants
  Phone: (919) 684-5175, Fax: (919) 684-6278

Submitting a grant

- Budget, abstract, and budget justification have to submitted to ORA (electronically using SPS system) AT LEAST 7 business days prior to grant deadline (they recommend 2 WEEKS to make sure it is approved before your deadline).

- After you get the OK from ORA, you are free to submit your grant. However, for NIH grants, which usually are electronic submissions, ORA will continue to be involved in your electronic grant submission (see below).

- For NIH grants, you need to have an account with eRA Commons. Your division administrative assistant (DAA) or the DoM grants office can help you set up this account. Contact your DAA, Departmental SPS Security Officer or ORA to get set up with an account.

- Your Departmental/Divisional grants administrator should be able to put in your budget, etc. into this system to get routed to ORA for approval prior to submission to the grant funding agency.

- All grants have to be approved by ORA before being submitted.

- While the grant is being approved, you can start uploading the relevant application-specific documents to Grants.Duke (https://grants.duke.edu). You will upload all of your NIH application materials at this website. You will need your Duke NetID and password to logon (see Chapter 1 for information on NetID). Some divisions have their administrators upload the grants.

    - The Grants.Duke website interfaces with the NIH website, so once you upload and submit everything through Grants.Duke, it gets transmitted to the NIH.

    - Once you get the approval from ORA, you can complete the final submission of your grant to the NIH. The Grants.Duke website will have all of the documents you submitted to ORA (budget, budget justification, abstract) already uploaded into Grants.Duke, so you do not need to re-upload those. In general, each section of the grant is separated (biosketches, budget, sections of the research plan, bibliography and sections of the Human Subjects) and made into pdf form for submission. Check with your Department/Divisional grants administrator about your particular grant, as the instructions may vary .

    - If you have questions or comments about the electronic submission process or other grant-related matters, please contact your Departmental or Divisional grants administrator or the Duke pre-award office:

        - School of Medicine and School of Nursing researchers should call the Office of Research Administration (ORA): 919-684-5175

- **Technical Support:** If you have technical problems with the SPS application or the Grants.Duke website, please contact the developers by calling the appropriate Help Desk. School of Medicine and School of Nursing users should call the DHTS Help Desk: 919-684-2243 or discuss with your division grants administrator.

eRA Commons

Electronic online system through NIH that allows investigators and staff to see: status of application, meeting dates, summary statement, notice of grant award, when non-competing continuation is due, and electronic submission of just-in-time information

Contact your DAA or department SPS office (someone in grants administration in your department) or ORA to get set up an account

Post-funding related issues

Your departmental or divisional grants administration should give you post-award expenditure reports, as well as helping with progress reports, non-competing and competing renewals. Work with your DAA to plan and interpret these reports.

Regulatory Issues

IRB ethics training is mandatory for anyone conducting human research, including investigators and all study staff. Duke uses the CITI modules; you will need to do several CITI modules each year. **https://www.citiprogram.org/Default.asp?**

- VA education requirements will be accepted for Duke faculty in lieu of other modules
- All investigators and study personnel will receive reminders when their IRB credentialing update is due, at 30 and 7-days prior to termination date.
- The eIRB will check the status of each key personnel member and if delinquent or within the 30-day window, it will send an email to the individual and the PI.

IRB submissions

- All Duke IRB submissions are now electronic, making IRB approval fairly easy and efficient. All signatures are acquired online electronically. http://irb.duhs.duke.edu/
- The IRB website will assign you a pre-reviewer who will do an in-depth review of the protocol. If you are submitting through the Department of Medicine, when you get to the page that asks you to designate an IRB reviewer, choose “Monica Harris” (Department Administrator); they will then assign you to a departmental reviewer. You will receive an email notice that feedback and suggested changes are posted on the website. After you make those changes, you can resubmit and the protocol will then go to full review at the IRB. In general, the IRB staff decides if a

protocol can undergo “expedited” vs. “full” review, but you can request expedited review with justification.

Clinical Research Support Office (CRSO)

- http://crso.som.duke.edu/

- Certain types of clinical research (i.e. clinical trials) are subject to the rules and regulations of site-based research (SBR) groups, including creation and management of charge-related grids. If you are conducting such research, please visit the CRSO website for more information. As of the writing of this chapter, this office is undergoing changes in how it interacts with the grants system, so be sure to check with your Department/Division grants administrator to be sure you have the most up-to-date information.

Site Based Research (SBR)

- An organizational structure has been developed in which a central group, the Medicine SBR will oversee industry-sponsored clinical trials. This group will assist you in budget preparation, IRB submission and submission of charges to the industry sponsor. In the Department of Medicine, two other SBRs are already in existence, Cardiology and Neurology. Therefore, if you are a member of these two divisions, your trials will be managed by these SBRs. All other divisions will be part of the Medicine SBR. This system is in evolution, so it’s wise to check with your Departmental/Divisional grants administrator if you are considering involvement in an industry trial. Be sure to do this early in the process before any budgets are constructed, contracts signed, etc.

Animal Research

- Before animals are ordered or used, you will need an animal use application, and you will need to complete online compliance training.

- These protocols and training modules can be found at: Office of Animal Welfare and Assurance: http://vetmed.duhs.duke.edu/IACUC.html

- The Duke animal program applications, forms, reports, or questions can be emailed to the Duke IACUC at Email address: IACUC@DUKE.EDU

- **Questions?** Email the Office of Animal Welfare Assurance (ron.banks@duke.edu or michelle.keys@duke,edu)

Library resources

The medical center library has a wide range of on-line resources and tutorials to facilitate research (http://www.mclibrary.duke.edu/training).
For example, see for a tutorial on PubMed, see https://mclibrary.duke.edu/tutorials-tipsheets/pubmed...there may be more to it than you know!

DoM Special Assistance

Please see Chapter 8 for information on DoM initiatives to facilitate career development awards and diversity supplement awards.

Frequently Asked Questions

What is the maximum percent effort allowed on grants? No faculty may be externally funded greater than 98% (11.76 calendar months) without written approval from the Vice Dean for Research (Dr. Sally Kornbluth).

What if I think my research is eligible for IRB Exemption? Even if a research protocol is exempt from IRB review, you need an "official" exemption from the IRB (filed electronically, usually just takes a few days).

Who counts as a "New Investigator" and "Early Stage Investigator"? A **New Investigator** is an NIH research grant applicant who has not yet been awarded a substantial, competing NIH research grant. For example, a Program Director/ Principal Investigator (PD/PI) who has previously received a competing NIH R01 research grant is no longer considered a New Investigator. However, a PD/PI who has received a small grant (R03) or an Exploratory, Developmental Research Grant Award (R21) retains his or her status as a New Investigator. For a complete list of NIH grants that do not disqualify a PD/PI from being considered a New Investigator, visit http://grants.nih.gov/grants/new_investigators/index.htm#definition

An **ESI**, or **Early Stage Investigator**, is a *New Investigator* who has completed his or her terminal research degree or medical residency—whichever date is later—within the past 10 years and has not yet been awarded a substantial, competing NIH research grant.
http://grants.nih.gov/grants/new_investigators/index.htm#earlystage
The dates that start the period of classification as an Early Stage investigator are entered in the investigators eRA Commons Profile (https://commons.era.nih.gov/commons/).

See NIH policy at http://grants.nih.gov/grants/new_investigators/index.htm

What is the difference between "Research Support" and "Other Support"?
"Research Support" is a section of the 4-page NIH biosketch. This form should include any RELEVANT current or past grants (for last three years) and should NOT include any percent efforts or dollar amounts. The intent of this section is to show reviewers previous funding success in areas relevant to the proposed project. This page CAN include VA-funded projects. "Other Support" is a separate document from "Research Support."

"Other Support" should only be provided when specifically requested by the Program Announcement or Request for Application (e.g., primary mentor on K grants and some training grants) or during the Just in Time process. This document SHOULD include

person-month effort and dollar amounts, and should include ALL funding sources: Commercial, federal, or foundation. This document should show all of the funding sources that support an individual's Duke research effort.

How can I find out which program officer to communicate with before submitting my first grant? It is part of their job to help investigators, and many are extremely helpful with application logistics and scientific questions. There are a few ways to identify an appropriate program officer:

- Ask someone in your department who has a grant in your specialty
- Call the "Extramural Program Official" listed for your institute of interest in this document: http://grants.nih.gov/grants/policy/nihgps_2003/NIHGPS_Part14.htm Explain to him or her what your research interest is and ask if they can recommend an appropriate contact.
- You can usually get specific names by looking at the individual institute's website. You can get there by going to http://www.nih.gov/ and choosing your institute. Once you get to the institute page, you have to search around for the info as each institute's webpage has its own design.
- If you see a Program Announcement or Request for Application that falls in your area of interest, the announcement will usually have specific Program Officers listed for various institutes.
- Call the Duke Office of Research Administration (684-5175). They can help you look.

Summary of websites in this chapter

Pre-Award, Office of Research Administration (Medical Center): http://research.som.duke.edu/

Pre-Award, Office of Foundation Relations (OFR): http://dumcdevelopment.duke.edu/staff_foundation.htm

Pre-Award, Office of Research Support: http://www.ors.duke.edu

Post-Award, Office of Sponsored Programs (SPS): http://www.finsvc.duke.edu/finsvc/CostReim/osp/

Duke IRB: http://irb.mc.duke.edu

Office of Animal Welfare and Assurance: http://vetmed.duhs.duke.edu/IACUC.html

Office of Science and Technology (OST, aka Office of Corporate Research Collaborations), useful if you are working with industry, filing intellectual property, patents, etc.: http://www.ostp.gov/

NIH office of extramural research: http://grants1.nih.gov/grants/oer.htm

Duke Translational Medical Institute has a website with tools for investigators including a CRF library, data collection systems information, communication tools, etc.: http://dtmi.dcri.duke.edu/dtmiworkspace/tools-and-reference

Office of Research Administration: http://research.som.duke.edu/

Clinical Research Support Office: http://crso.som.duke.edu/

Scholars@Duke: https://scholars.duke.edu

Projector Reporter Database: http://projectreporter.nih.gov/reporter.cfm

PEDIGENE ® Informatics: http://wwwchg.duhs.duke.edu/research/clinical.html

Biobanking Core: http://wwwchg.duhs.duke.edu/research/dnabank.html

Molecular Genomics Core: http://wwwchg.duhs.duke.edu/research/molecular.html

School of Medicine Core Research Facilities: http://basicscience.medschool.duke.edu/modules/bsci_rinfo/index.php?id=2

Duke Funding Opportunities: http://researchfunding.mc.duke.edu

NIH Funding Opportunities and Notices: http://grants1.nih.gov/grants/guide/index.html

Federal Grants: http://www.grants.gov/applicants/find_grant_opportunities.jsp

DUMC Library tutorials: http://www.mclibrary.duke.edu/training

DUMC Library tutorial on PubMed: https://mclibrary.duke.edu/tutorials-tipsheets/pubmed

NIH New and Early Stage Investigator Policies: http://grants.nih.gov/grants/new_investigators/index.htm

Definition of New Investigator: http://grants.nih.gov/grants/new_investigators/index.htm#definition

Definition of Early Stage Investigator:
http://grants.nih.gov/grants/new_investigators/index.htm#earlystage

NIH Homepage: http://www.nih.gov/

Chapter 5: Teaching Responsibilities at Duke Hospital

In this chapter you will find:

1. Guidelines for attending on the General Medicine inpatient service at Duke Hospital.

2. Guidelines that interns, residents and night residents receive so that you can be familiar with the Residency Program's expectations for the housestaff.

3. Admission pager policy

4. Guidelines for effective handoffs and physician sign out.

5. Primer on effective Ward Rounding for housestaff.

6. General Medicine 8100 & 8300 Step Down criteria.

7. General Medicine Rotation Map for Residents (including goals and objectives).

8. Inpatient Resident Evaluation (electronically in MedHub) with behavioral anchors.

9. Performance Services and Patient Satisfaction website.

Information current as of August 2013

NOTE: This chapter pertains only to Duke Hospital. Guidelines for attending at Durham Regional Hospital and the VA Hospital can be found in other chapters of this orientation package.

DukeMedicine

Department of Medicine
Hospital Medicine Program

Duke General Medicine Service

The Duke General Medicine service is one of the largest clinical and teaching services at Duke North Hospital, with an average daily census of over 97 patients in intermediate care beds, and over 5000 discharges anticipated in this fiscal year. Our primary source of admissions is the Duke Emergency department, though patients are directly admitted from numerous Duke primary care and specialty clinics, and transfers are accepted from hospitals throughout North Carolina, Virginia, West Virginia, Tennessee, and South Carolina.

The Duke General Medicine teaching services consist of:

General Medicine Team 1-5	General Medicine Faculty teaching teams
General Medicine Team 6-10	Hospital Medicine Faculty non-teaching teams
General Medicine Team 9	Lead Hospitalist Faculty Team and Duke General Medicine Consults
General Medicine Team 12	Duke Medicine-Psychiatry team

Each of the 5 General Medicine teaching teams consist of a senior medicine resident team leader (PGY 3 Medicine, PGY 3 or 4 Medicine-Pediatrics, or PGY 4, or 5 Medicine-Psychiatry resident), two medicine interns, one or two second year medical students, one fourth year medical student or PA student. Each physician team is assigned a full-time Patient Resource Manager (case manager) and rounding pharmacist or PharmD student.

For additional information about the structure and schedule of our teaching services, please see the Duke General Medicine Intern and Resident Orientation materials (below).

The Hospital Medicine Faculty services, General Medicine 6-10, will accept daily admissions of appropriate nonteaching cases from the Duke ED, clinics, and night hospitalist patients admitted overnight by our faculty or night residents

The General Medicine Consult Service is staffed by our daily lead Hospital Medicine Faculty member Monday through Friday for daytime consultations from our surgical colleagues at Duke. In addition, this faculty member may be assigned a smaller cohort of nonteaching inpatients, and will take calls and review requests from the Duke Transfer Center.

Expectations for Faculty Rounding on the Duke General Medicine Service

Clinical Duties:

- **Personally evaluate and examine all patients** admitted to your service within 24 hours of admission and on a daily basis. Work with the resident team to provide outstanding, efficient, and timely care for your patients.
- **Document** with attending notes and appropriate billing to confirm your involvement in patient care. Our divisional compliance representative from the PDC/PRMO will review with you appropriate documentation requirements, and you may also refer to the quick reference sheet attached.
- **Provide 24-hour support for residents** and interns in the management of patients on your service. Residents should be able to reach you by page at all times.
- **Conduct Attending Rounds** daily.
- **Duty Hours and Schedule:** Please see the recommended daily schedule detailed in the intern and senior resident orientations (found below).
- It is expected that residents will have the opportunity to attend resident report and noon conferences on Monday through Thursday, Medicine Grand Rounds on Friday morning at 8:00 A.M., and Chair's Conference on Friday at 12:00 P.M.
- To best evaluate the changes to Duke General Medicine we will monitor physician and nursing feedback, patient outcomes, and teaching evaluations. We will continue to make changes to improve our teaching and clinical paradigm.

Education:

- Establish goals and expectations for your team at the beginning of your scheduled weeks on service with them.
- Provide both formal and informal didactics related to patient care issues as well as topics related to your field of interest on rounds and throughout the course of the day.
- Give constructive, timely feedback to residents and students on their performance while on your team and at the conclusion of your time with them. For the residents, the six clinical competencies of patient care, fund of knowledge, practice-based learning and improvement, interpersonal communication skills, professionalism and system-based practice should be addressed with suggestions for improvement.
- Complete written evaluations using Medhub (medhub.duke.com) at the end of the resident rotation, and sign-off on documented procedures using the same electronic system.
- We are using a MILESTONE BASED EVALUATION SYSTEM, as of July 2013. This is a national requirement, and we have adapted the "universal" milestone based evaluation published by the ACGME into our own smaller

evaluations, pertinent to general medicine and night resident. There is a video available for you in medhub to review the process.

Professionalism:

- Foster a collegial work environment for all members of the General Medicine team, and work collaboratively to ensure outstanding patient care.
- Demonstrate professional communication and interactions for other team members.
- Model "Etiquette-Based Medicine" in patient encounters:
- WASH HANDS!
  - Knock, ask permission to enter patient rooms and wait for an answer.
  - Introduce yourself, showing your ID badge and offering your business card.
  - Shake hands
  - Sit down if possible, smile if appropriate.
  - Briefly explain your role on the team.
  - Ask the patient about how he or she is feeling about being in the hospital.
  - After your examination and discussion with the patient, conclude your encounter by asking if the patient has any further questions, or if there is anything that they need at the moment.

DukeMedicine

Internal Medicine
Residency Training Program

2013-2014 DUKE GENERAL MEDICINE INTERN ORIENTATION

OVERVIEW:

Duke General Medicine (Gen Med) will be one of the most rewarding rotations of your intern year. During this rotation, you will serve as the primary physician for a cohort of patients, and an integral member of your patients' health care team. In this role, you will care for a diverse patient population that often has a very high acuity of illness and learn to work in a multidisciplinary team.

Remember that taking care of your patients is a remarkable privilege.
Physicians are never inconvenienced by sick patients.

GENERAL MEDICINE SERVICES:

There are eleven general medicine (GM) teams:

- GM1-5: Resident General Medicine services
- GM 6-10: Hospital Medicine Faculty service, including an inpatient procedure service (GM10) when operating at full capacity*
- GM 12: Medicine/Psychiatry service

You will rotate on one of the five intern/resident services (GM 1-5).

Each GM resident team is comprised of the following:

- 1 Attending physician
- 1 Daytime Supervising Resident
- 2 Interns (team co-interns)
- 1 Night Resident
- 2 Students (2nd year Medical Student or Physician Assistant student)
- 1 Sub-intern (4th year medical student, typically only present in the fall)
- Patient resource manager (PRM)
- Pharmacist and/or PharmD student

SCHEDULE (overview):

WEEKDAYS:

TYPICAL WEEKDAY:

7:00 AM Meet team night resident at designated handoff area. Receive update on overnight events on old patients and proceed to bedside for brief encounter with patients that were admitted overnight to team or had significant events develop overnight. While one intern is at bedside receiving handoff, the other can be outside the room reviewing labs and vitals on their service.
7:30 AM Team work rounds on all patients.
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on discharges and new admissions, teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work, including evaluating new admissions.
12:00 PM Team attends Medicine Noon Conference (DN2002).
1:00 PM Duke Resident Report DN8253 (M-Th) for senior resident, interns continue daily work.
2:00 PM Stead Rounds (preferential time) based on pre-arranged rounding times, twice weekly.
6:30 PM Evening Handoff to team night resident at designated handoff area. Again, brief bedside encounter for patients who are newly admitted or sick is encouraged.

RESIDENT CLINIC DAY:

7:00 AM Morning Handoff from Night Residents as above
7:30 AM Team work rounds on all patients.
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on discharges and new admissions, teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work.
12:00 PM Team attends Medicine Noon Conference (DN2002).
1:00 PM Resident attends continuity clinic while interns cover service, with attending and chief/ACR back-up (no new admissions in afternoon).
5:00 PM Evening Handoff to team night resident as above at designated hand-off area.

INTERN CLINIC DAY:

7:00 AM Morning Handoff from Night Residents as above
7:30 AM Team work rounds on all patients.
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on discharges and new admissions, teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work,
12:00 PM Team attends Medicine Noon Conference (DN2002)
1:00 PM Interns attend continuity clinics while resident covers clinical service.
1:00 PM Duke Resident Report DN8253 (M-Th) for senior resident
5:00 PM Evening Handoff to team night resident as above at designated hand-off area.

LONG CALL DAY:

7:00 AM Morning Handoff from Night Residents as abov.e
7:30 AM Team work rounds on all patients.
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on discharges and new admissions, teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work,
12:00 PM Team attends Medicine Noon Conference (DN2002).
1:00 PM Duke Resident Report DN8253 (M-Th) for senior resident
7:00 PM Continue clinical work on new admissions from day. Resident will attend signout rounds with chief resident and ACR. Occasionally entire team will attend night signouts with CR, ACR and Dr Klotman in the Med Res library (8pm, schedule TBD)
By 9:00 PM Completed clinical work and transition of responsibility to team night resident. The “long call” team’s Night resident will be off this night and the team will handoff patients to the 1010 Night Resident. Similar expectations for concise and precise information exchange with emphasis on bedside encounters for new or sick patients remain.

WEEKENDS:

RESIDENT DAY OFF (Friday, Saturday, or Sunday):

7:00 AM Morning Handoff from Night Residents as above
7:30 AM Team work rounds on all patients
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on all discharges, new admissions, teaching rounds on remaining patients.
11:00 AM Intern team continues clinical work with potential admission of 1-2 new patients in morning per Intern (before noon)
5- 6:30PM Evening Handoff to night residents as above

INTERNS DAY OFF (Saturday or Sunday):
7:00 AM Morning Handoff from Night Residents as above
7:30 AM Resident work rounds on all patients
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on all discharges, new admissions, teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work with admissions of new patients, coverage of 1010
5-6:30 PM Evening Handoff to night residents as above

DAILY RESPONSIBILITIES:

Interns are the first line physicians when it comes to patient calls from nurses. In order to be easily accessible, please be sure to sign onto your team's functional pager at the beginning of the rotation and ensure all patients have updated correctly identifiable providers listed in CPOE.

Interns are responsible for writing effective daily progress notes (on up to 10 patients), ordering necessary diagnostic studies (laboratory, radiology, etc), and following up on pending results in a timely fashion. Interns are also responsible as a part of the team to communicate with patients and families daily about their clinical course and plan of care including discharge. **Interns are responsible for discharge summaries on patients hospitalized for 3 days or less. Discharge summaries ideally will be completed on the same day as the patient's discharge, however if this is not possible, the summary *must* be completed within 24 hours of discharge.**

Anticipate and prepare for discharges in a timely manner. Goal is for patients anticipated to be discharged the following day to have discharge paperwork, prescriptions, follow-up appointments, medication reconciliation completed on the afternoon prior to anticipated discharge for review with the patient and your supervising resident and attending physicians.

Please report to your designated handoff location to meet Night Residents at appropriate time. Prior to this time, be sure to update the electronic patient list (adding new patients, deleting discharged patients, adding important new information, delineating things that need follow-up overnight). Keeping the list up to date is an important aspect of safe patient care and is as important as an effective verbal transition of responsibility. This also allows timely tracking of overall patient census data which informs decisions for patient distribution during various points in the day. Bring a copy of the patient list with you when you meet with your team's night resident for handoff so they may refer to it at night.

NEW ADMISSIONS:

The medicine teams will admit new patients daily. On days when a team member (either resident or intern) is in clinic, we will attempt to not assign new admissions to that team unless there is a re-hospitalization of a prior patient, unit transfer, or very high volume of admissions, or if team census necessitates. On Monday-Friday, one team is designated as the "Long Call" team and will typically receive admissions early in the morning and later in the afternoon with expectation that they would stay beyond 7pm to complete workups but transition care and responsibility to their night resident and leave by 9pm. The teams that are not "Long Call" will typically receive admissions earlier in the day with expectation that they would be able to complete workup and transition care and responsibility to night resident at evening handoff.

Admitting a patient includes completing the entire electronic admission database, entering admission orders, and updating the electronic patient list. The **H&P database form must be complete** before you transition care to another provider (pay particular attention to pain score, functional status, vaccinations, review of systems, multisystem exam, and present on admission conditions). Medication reconciliation is one of the most crucial components of the admission process! Formulate a detailed, specific, and prioritized problem list that notes both acuity and severity of problems as well as a concise summary of the plan that your team formulates for the patient.

DAILY NOTES:

Timely and appropriately detailed documentation of your patient encounters and plans is essential. Review and document the pertinent historical elements for the problems the patient is being treated for and detail any new symptoms or events. Note vital signs and a daily focused physical exam. There are electronic templates available for complete daily notes. Interpret and summarize abnormal lab values, radiology/pathology reports in the progress notes section. All medications should have a corresponding diagnosis and should be reviewed both on daily work rounds and while writing your daily note. **Be as specific as possible in your problem list** (see examples below), and prioritize problems by severity and acuity. Avoid system/organ based problem lists.

- Example #1: Acute left ventricular systolic heart failure rather than CHF
- Example #2: After you have diagnosed the patient with a pulmonary embolism, the problem is no longer the symptom of dyspnea or chest pain

DISCHARGE SUMMARIES:

Interns are responsible for discharge summaries on patients hospitalized for 3 days or less. Discharge summaries ideally will be completed on the same day as the patient's discharge, however if this is not possible, the summary *must* be completed within 24 hours of discharge. (See template form for information to be included)

DISCHARGE PLANNING:

- As soon as medically appropriate, discontinue IV fluids, convert IV meds to oral, set up home services with PRM, place PICC lines if needed, and prepare patient and family for any discharge needs the day(s) before discharge when these are determined.
- Discharge planning should begin early in the patient's hospital course. This includes timely communication with family members to keep them updated on plans for discharge.
- Discharge in early AM whenever feasible is an important way to improve patient satisfaction and hospital workflow. Our goals are for **discharge paperwork, follow up appointments, medication reconciliation, and prescriptions to be completed the day prior to anticipated discharge and reviewed the afternoon prior to anticipated discharge by the entire team (intern, resident, attending)** to ensure the safest and most appropriate discharge plan.
- Clarify with patient, family, and PRM who will be transporting the patient at discharge and set discharge time in advance. Notify the charge nurse and care nurse of discharge plans.
- Paperwork should be finalized with resident and attending on the morning of discharge, and discharge order placed as soon as possible to facilitate a timely and seamless discharge process. Anticipate that the process of nurse completion of their discharge duties (going over instructions, removing IV, telemetry, assessment of vitals) takes additional time and cannot always be done immediately following an order being placed. **.**
- **Contact PCP (by email or phone) to inform them of admission and discharge** – this will also help you in planning disposition. Be sure to communicate to outpatient providers and document in the discharge summary studies or lab work that is pending at time of discharge or anticipated need for further studies at follow-up appointment. For patients whose follow-up is outside of the Duke Health System, auto-fax options for discharge summaries will allow for timely correspondence with their providers. The discharge summary must be signed by attending in order for the document to be sent.
- ***Medication List on DC paperwork and DC summary must match. This is particularly important for communication with other facility transfers (SNF, Psychiatric hospital, other acute care hospital). When there are discrepancies, it causes extra work for the PRM and you will be asked to redo the required forms. This is an essential way to ensure a safe transition from inpatient care to the community or other facilities.***
- All verbal orders must be signed by a physician before a patient is discharged.

INTERN REPORT:

Interns will attend intern report on Wednesdays at 3:30pm in the Medicine Resident's Library. All interns are expected to attend. This report will focus on case presentations, and give interns the opportunity to discuss cases from their services with their colleagues, the chief resident, and the faculty member in attendance. The Assistant Chief Resident will send a schedule out prior to the rotation that will list which interns are scheduled to present. Students are welcome to this conference.

DAYS OFF:
Each intern and resident will have an average of one day off per week. These days are specified in the schedule and will be on Saturday or Sunday. Any alteration to day off schedule must be approved by the chief resident in advance.

DUTY HOURS:
- Interns and residents should work no more than 75 hours per week. If you find yourself having difficulty staying within duty hours, contact your supervising resident, attending, chief resident or ACR to identify strategies to assist you.
- All house staff should have a 10h period off between shifts. In order to allow for this, both interns and resident should leave no later than 9pm on the "long-call" day following effective transition of care to night resident. If you have difficulty, contact any of the above for useful strategies
- Duty hours should be reported at least on a weekly basis in MedHub. Failure to do so can result in being pulled from service.

PATIENT VOLUMES:
Each Gen Med team has a patient volume limit of 20 total patients. Each intern can be the primary physician for no more than 10 patients at any given time (note that this number does not include cross-cover). On very rare occasion, redistribution of patients may need to occur in order to avoid exceeding these limits.

TRANSITIONS OF RESPONSIBILITY:
- Safe and effective handoffs are important to our patients care.
- Handoffs are scheduled to commence at designated handoff areas at the beginning and end of every day, and with decentralization and reduction in the number of teams being covered, an emphasis is now placed on brief bedside encounter for new or sick patients.
- Model good handoff behavior
    - Use consistent system and structure to handoffs.
    - Be on time and at appropriately designated location
    - Minimize interruptions and distractions during the handoff process
    - Have the person who is accepting handoff repeat critical tasks or information (read-back technique)
    - Use clear, explicit, and unambiguous language
    - Allow the person who is accepting handoff ask questions (interactivity)
    - Identify sick and new patients and strongly consider joint evaluation at bedside
- Suggested Technique – **SIGNOUT?**
    - **S**: Is this patient particularly **S**ick or DNR
    - **I**: **I**dentifying data and demographic info about patient
    - **G: G**eneral hospital course for the patient
    - **N**: **N**ew events or occurrences of the day
    - **O: O**verall Health status

  - **U**: **U**pcoming possibilities and things to watch for
  - **T**: **T**asks that need to be completed prior to next handoff
  - **?**: Any questions**?**
- You will be observed at least once during this rotation and be provided with feedback on your transition of responsibility.

BACK UP:
You are never alone! Never be afraid to ask for help, it is not a sign of weakness, rather it is a sign of wisdom. Often, it is better to ask for help early if you are uncomfortable. The Gen Med back-up team includes:

- Supervising team resident or nighttime resident
- Team Attending physician
- MICU consult resident and MICU fellow
- Assistant Chief Resident (681-6529) and Chief Resident (681-5918)
- Hospital Medicine Lead Attending (GM9 – 970-7777)

Always call the team attending and resident if a patient dies, is transferred to an ICU, requires an emergent or unexpected surgical procedure, or has a change in advanced directives to allow a natural death (the attending must participate in all verbal DNAR orders, day or night, with the care nurse as a phone witness).

EMERGENCY SITUATIONS:

- **RRT (rapid response team)**: If a patient has unstable vital signs, an acute change in mental status, or a clinical deterioration that is concerning, you can call an RRT. The purpose of this system is to call nurses (including the charge nurse from the MICU), respiratory therapists, and operations administrators to the patient's bedside for assistance in patient management and triage. An RRT can be called by any nurse, intern, resident, respiratory therapist, etc. If another member of the healthcare team wants to call an RRT, you may not stop them. It is not a sign of weakness or poor medical care if an RRT is called on your patient.

- **CODE BLUE:** Should be called in the event of a cardiac/respiratory arrest. The code team consists of the MICU resident, CCU intern, and CCU resident, nurses, and operations administrators. The stroke code team includes a neurology resident. As the covering intern, your job is to convey as much about the patient's history, hospital course, recent labs, etc. to the code team.

- **STROKE CODE:** Should be called in event of a suspected acute stroke (new slurred speech, weakness, numbness or other acute focal neurologic change). The stroke code will get prompt evaluation by the covering neurology resident, will mobilize resources for a stat head CT, and operations administrators in the event the patient requires a higher level of care.

INPATIENT PROCEDURE SERVICE:

- A trained Hospital Medicine attending will be available to supervise bedside procedures performed on patients hospitalized at Duke from 8am-6pm, 7 days per week. Night coverage is often available as well, so please contact them as needed. ***Note that this service is available when GM 6-10 are functioning at full capacity.***
- Bedside procedures include central line placement, thoracentesis of uncomplicated effusions, paracentesis (both diagnostic and therapeutic), arthrocentesis, and lumbar puncture.
- For some of these procedures (central line placement, thoracentesis and paracentesis) the attending will be able to assist with ultrasound guidance.
- The intern/resident will still perform the procedure under the supervision of the attending.
- To contact the procedure attending, please page **970-7409**.

PROCEDURES:

- Must be done with supervision unless resident is certified (i.e., has met the program requirements)
- Be sure to write a procedure note (template available)
- Use appropriate protection (including eye protection!) and sterile technique
- Any procedure involving a body fluid or needle has potential to cause an exposure
- Any procedure involving a body fluid or needle has potential to cause an exposure. If exposure occurs, please notify your supervisor and call 115 for guidance from occupational health
- ***Must perform time out and document in chart*** (two people confirm person, site, procedure)

GENERAL TIPS:

- Be sure to eat, hydrate, and use the restroom. You can't take care of patients if you don't take care of yourself.
- Dress professionally. Remember you are someone's doctor!
- Go to conferences. You only do internship/residency once!
- Be absolutely compulsive. Follow-up all labs, studies, etc. You are the net to catch all details before they fall through the cracks. The New Results tab on eBrowser is an excellent way to prevent this from happening and to stay up to date on the latest events for your patients.
- Write things down –. Make a to-do list. No matter how large your brain is, you will not be able to remember every detail about the care of every patient. It is NOT a sign of weakness….
- Page the pharmacist if you have medication questions. They are always available and a great resource
- Be proactive in discharge planning & talk to your PRM daily.
- Work collegially with ALL staff, not just physicians. When you are frustrated, take a deep breath and take the high road.

- Keep the patient's nurse involved and up to date with your plans, this will cut down on pages and ultimately make your life better (in addition to offering better patient care).

DukeMedicine

Department of Medicine
Hospital Medicine Program

2012-2013 DUKE GENERAL MEDICINE SENIOR RESIDENT ORIENTATION

Your responsibilities and goals as the supervising resident on the Duke General Medicine Service have shifted to focus on leadership, decision-making, and teaching. Over this rotation, you will have the opportunity to develop your clinical, communication, and leadership skills as you oversee the care of acutely ill medical patients at our largest teaching service and manage a multidisciplinary team of providers and students.

GENERAL MEDICINE SERVICES:

There are eleven general medicine (GM) teams:

- GM1-5: Resident General Medicine services
- GM 6-10: Hospital Medicine Faculty service, including an inpatient procedure service (GM10) when operating at full capacity*
- GM 12: Medicine/Psychiatry service

You will rotate on one of the five intern/resident services (GM 1-5).

Each GM resident team is comprised of the following:

- 1 Attending physician
- 1 Daytime Supervising Resident
- 2 Interns (team co-interns)
- 1 Night Resident
- 2 Students (2nd year Medical Student or Physician Assistant student)
- 1 Sub-intern (4th year medical student, typically only present in the fall)
- Patient resource manager (PRM)
- Pharmacist and/or PharmD student

SCHEDULE (overview):

WEEKDAYS:

TYPICAL WEEKDAY:

7:00 AM Meet team night resident at designated handoff area. Receive update on overnight events on old patients and proceed to bedside for brief encounter with patients that were admitted overnight to team or had significant events develop overnight. While one intern is at bedside receiving handoff, the other can be outside the room reviewing labs and vitals on their service.

7:30 AM Team work rounds on all patients.
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on discharges and new admissions, teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work, including evaluating new admissions.
12:00 PM Team attends Medicine Noon Conference (DN2002).
1:00 PM Duke Resident Report DN8253 (M-Th) for senior resident, interns continue daily work.
2:00 PM Stead Rounds (preferential time) based on pre-arranged rounding times, twice weekly.
6:30 PM Evening Handoff to team night resident at designated handoff area. Again, brief bedside encounter for patients who are newly admitted or sick is encouraged.

RESIDENT CLINIC DAY:

7:00 AM Morning Handoff from Night Residents as above
7:30 AM Team work rounds on all patients.
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on discharges and new admissions, teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work.
12:00 PM Team attends Medicine Noon Conference (DN2002).
1:00 PM Resident attends continuity clinic while interns cover service, with attending and chief/ACR back-up (no new admissions in afternoon).
5:00 PM Evening Handoff to team night resident as above at designated hand-off area.

INTERN CLINIC DAY:

7:00 AM Morning Handoff from Night Residents as above
7:30 AM Team work rounds on all patients.
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on discharges and new admissions, teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work,
12:00 PM Team attends Medicine Noon Conference (DN2002)
1:00 PM Interns attend continuity clinics while resident covers clinical service.
1:00 PM Duke Resident Report DN8253 (M-Th) for senior resident
5:00 PM Evening Handoff to team night resident as above at designated hand-off area.

LONG CALL DAY:

7:00 AM Morning Handoff from Night Residents as abov.e
7:30 AM Team work rounds on all patients.
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on discharges and new admissions, teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work,
12:00 PM Team attends Medicine Noon Conference (DN2002).
1:00 PM Duke Resident Report DN8253 (M-Th) for senior resident
7:00 PM Continue clinical work on new admissions from day. Resident will attend signout rounds with chief resident and ACR. Occasionally entire team will attend night signouts with CR, ACR and Dr Klotman in the Med Res library (8pm, schedule TBD)
By 9:00 PM Completed clinical work and transition of responsibility to team night resident. The "long call" team's Night resident will be off this night and the team will handoff patients to the 1010 Night Resident. Similar expectations for concise and precise information exchange with emphasis on bedside encounters for new or sick patients remain.

WEEKENDS:

RESIDENT DAY OFF (Friday, Saturday, or Sunday):

7:00 AM Morning Handoff from Night Residents as above
7:30 AM Team work rounds on all patients
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on all discharges, then teaching rounds on remaining patients.
11:00 AM Intern team continues clinical work with potential admission of 1-2 new patients in morning per Intern (before noon)
5- 6:30PM Evening Handoff to night residents as above

INTERNS DAY OFF (Saturday or Sunday):

7:00 AM Morning Handoff from Night Residents as above
7:30 AM Resident work rounds on all patients
9:00 AM Attending briefing with team regarding patient updates and possible morning discharges.
9:15 AM Bedside attending rounds on all discharges, then teaching rounds on remaining patients.
11:00 AM Resident team continues clinical work with admissions of new patients, coverage of 1010
5-6:30 PM Evening Handoff to night residents as above

DAYS OFF:

- Every intern and resident will have one day off per week.

  - Residents should also see that sub-I's and students also get one day off per week
- Resident day off will be on Friday, Saturday, or Sunday during the week.

DUTY HOURS:

- Interns and residents should work no more than 75 hours per week. If you find yourself having difficulty staying within duty hours, contact your attending, chief resident or ACR to identify strategies to assist you.
- All house staff should have a 10h period off between shifts. In order to allow for this, both interns and resident should leave no later than 9pm on the "long-call" day following effective transition of care to night resident. If you have difficulty, contact any of the above for useful strategies**.**
- Duty hours should be reported at least on a weekly basis in MedHub. Failure to do so can result in being pulled from service.

NEW ADMISSIONS:

The medicine teams will admit new patients daily. On days when a team member (either resident or intern) is in clinic, we will attempt to not assign new admissions to that team unless there is a re-hospitalization of a prior patient, unit transfer, or very high volume of admissions, or if team census necessitates. On Monday-Friday, one team is designated as the "Long Call" team and will typically receive admissions early in the morning and later in the afternoon with expectation that they would stay beyond 7pm to complete workups but transition care and responsibility to their night resident and leave by 9pm. The teams that are not "Long Call" will typically receive admissions earlier in the day with expectation that they would be able to complete workup and transition care and responsibility to night resident at evening handoff.

Admitting a patient includes completing the entire electronic admission database, entering admission orders, and updating the electronic patient list. The **H&P database form must be complete** before you transition care to another provider (pay particular attention to pain score, functional status, vaccinations, review of systems, multisystem exam, and present on admission conditions). Medication reconciliation is one of the most crucial components of the admission process! Formulate a detailed, specific, and prioritized problem list that notes both acuity and severity of problems as well as a concise summary of the plan that your team formulates for the patient.

READMISSION / BOUNCE BACKS:

- Bounce backs follow either the intern or the resident on service. The goal is to preserve continuity of care for the patient as well as continuity of practice and education for the house staff. It is easier to admit a patient who is known to your team than to transfer care to another team so strict timelines as previously outlined no longer apply.

- For ICU transfers, your team should follow the progress of patients they had transferred to the ICU and be prepared to have them return to their team at any point.

PATIENT VOLUMES:
Each Gen Med team has a patient volume limit of 20 total patients. Each intern can be the primary physician for no more than 10 patients at any given time (note that this number does not include cross-cover). On very rare occasion, redistribution of patients may need to occur in order to avoid exceeding these limits.

RESIDENT REPORT – DN8253 MONDAY-THURSDAY AT 1:00 PM SHARP:

- **Management Discussion** – typically Tuesdays with Dr. Govert, but may be scheduled on other days based on case selected, faculty discussant and resident preference. Dr Govert will bring a case of his own for the beginning of report.
    - The goal is to focus on literature related to the management of general medicine inpatient scenarios and to hone critical management decision-making skills.
    - Residents will present a recent (within the last 7 days) case to the group.
    - As part of the case presentation, all imaging, EKGs, etc should be displayed and findings reviewed.
    - The case presentation should be fairly brief (15minutes).
    - All residents may then be asked to commit to a management strategy at discrete points during the patient's course.
    - The presenting resident should be prepared to discuss the literature related to the management of the problem at hand. Please be sure to forward relevant articles to the ACR the day before.
    - This is always a fun and interactive discussion/debate!
- **Cases** – the usual interactive case presentation, the case should be a patient on your service if possible.
    - If you have a patient with particularly interesting physical findings, please let the ACR or chief resident know before hand so that we can plan to go see/examine the patient during report.
    - Try to distill the case into a discrete teaching point and supplement that teaching point with primary literature whenever possible. We are not doing formal critically appraised topics (CATs) but do expect the residents to be incorporating the relevant evidence into their clinical care and into their teaching of peers and students
- Please participate, ask questions, join the debate, and have fun learning!

DISCHARGE SUMMARIES:
Interns are responsible for discharge summaries on patients hospitalized for 3 days or less. Discharge summaries ideally will be completed on the same day as the patient's discharge, however if this is not possible, the summary *must* be completed within 24

hours of discharge. Residents should work with the interns to ensure all patients have a discharge summary

DISCHARGE PLANNING:

- As soon as medically appropriate, discontinue IV fluids, convert IV meds to oral, set up home services with PRM, place PICC lines if needed, and prepare patient and family for any discharge needs the day(s) before discharge when these are determined.
- Discharge planning should begin early in the patient's hospital course. This includes timely communication with family members to keep them updated on plans for discharge.
- Discharge in early AM whenever feasible is an important way to improve patient satisfaction and hospital workflow. Our goals are for **discharge paperwork, follow up appointments, medication reconciliation, and prescriptions to be completed the day prior to anticipated discharge and reviewed the afternoon prior to anticipated discharge by the entire team (intern, resident, attending)** to ensure the safest and most appropriate discharge plan.
- Clarify with patient, family, and PRM who will be transporting the patient at discharge and set discharge time in advance. Notify the charge nurse and care nurse of discharge plans.
- Paperwork should be finalized with resident and attending on the morning of discharge, and discharge order placed as soon as possible to facilitate a timely and seamless discharge process. Anticipate that the process of nurse completion of their discharge duties (going over instructions, removing IV, telemetry, assessment of vitals) takes additional time and cannot always be done immediately following an order being placed. **.**
- **Contact PCP (by email or phone) to inform them of admission and discharge** – this will also help you in planning disposition. Be sure to communicate to outpatient providers and document in the discharge summary studies or lab work that is pending at time of discharge or anticipated need for further studies at follow-up appointment. For patients whose follow-up is outside of the Duke Health System, auto-fax options for discharge summaries will allow for timely correspondence with their providers. The discharge summary must be signed by attending in order for the document to be sent.
- ***Medication List on DC paperwork and DC summary must match. This is particularly important for communication with other facility transfers (SNF, Psychiatric hospital, other acute care hospital). When there are discrepancies, it causes extra work for the PRM and you will be asked to redo the required forms. This is an essential way to ensure a safe transition from inpatient care to the community or other facilities.***
- All verbal orders must be signed by a physician before a patient is discharged.

STUDENTS:

- **Set expectations:** At the beginning of rotation clarify your expectations for students – this should be the basis of your later evaluation.
- **Take time to teach** particularly on work rounds and in downtime.

- Student documentation
    - Both PA-S/MS2 and MS4/Sub-I notes must be reviewed and co-signed by the intern or the resident on the team. Give feedback to your students on their notes.
    - **Online progress notes must entered by a physician**
- **Give feedback often** – weekly at a minimum.
- Please make sure that the students get to all their required teaching conferences.
- Sub-Intern Note Specifics - sub-interns cannot complete E-Sig electronic H&Ps.
    - Resident does electronic H&P (maintains focus on assessment and plan with literature citation in the electronic document), sub-I does separate admission note, both notes printed and in chart for attending rounds.

CONFERENCES:

- ***Required, including Grand Rounds***
- Tell ACR about good cases, EKGs, CT's, physical findings etc., for gallops, EKG conference, Chair's, M&M...

ATTENDING COMMUNICATION:

- **Contact your attending prior to starting on service to plan out your weeks together. This will set the tone for a great month of co-managing a complex medical service.**
- Call your attending for critical or unexpected changes in clinical status: ICU transfer, urgent/unplanned procedure, AMA discharge, or death.
- Prioritize rounds and let your attending know which patients need to be seen early in the day on rounds
- Call your attending if a patient has a change in advance directives to allow a natural death (the attending must participate in all verbal DNAR orders day or night with the care nurse as a phone witness)

INPATIENT PROCEDURE SERVICE:

- A trained Hospital Medicine attending will be available to supervise bedside procedures performed on patients hospitalized at Duke from 8am-6pm, 7 days per week. Night coverage is often available as well, so please contact them as needed. ***Note that this service is available when GM 6-10 are functioning at full capacity.***
- Bedside procedures include central line placement, thoracentesis of uncomplicated effusions, paracentesis (both diagnostic and therapeutic), arthrocentesis, and lumbar puncture.
- For some of these procedures (central line placement, thoracentesis and paracentesis) the attending will be able to assist with ultrasound guidance.
- The intern/resident will still perform the procedure under the supervision of the attending.
- To contact the procedure attending, please page **970-7409**.

PROCEDURES:

- Must be done with supervision unless resident is certified (i.e., has met the program requirements)
- Be sure to write a procedure note (template available)
- Use appropriate protection (including eye protection!) and sterile technique
- Any procedure involving a body fluid or needle has potential to cause an exposure
- Any procedure involving a body fluid or needle has potential to cause an exposure. If exposure occurs, please notify your supervisor and call 115 for guidance from occupational health
- ***Must perform time out and document in chart*** (two people confirm person, site, procedure)

TRANSITIONS OF RESPONSIBILITY:

- Safe and effective handoffs are important to our patients care.
- Handoffs are scheduled to commence at designated handoff areas at the beginning and end of every day, and with decentralization and reduction in the number of teams being covered, an emphasis is now placed on brief bedside encounter for new or sick patients.
- Model good handoff behavior
    - Use consistent system and structure to handoffs.
    - Be on time and at appropriately designated location
    - Minimize interruptions and distractions during the handoff process
    - Have the person who is accepting handoff repeat critical tasks or information (readback technique)
    - Use clear, explicit, and unambiguous language
    - Allow the person who is accepting handoff ask questions (interactivity)
    - Identify sick and new patients and strongly consider joint evaluation at bedside
- Suggested Technique – **SIGNOUT?**
    - **S**: Is this patient particularly **S**ick or DNR
    - **I**: **I**dentifying data and demographic info about patient
    - **G: G**eneral hospital course for the patient
    - **N**: **N**ew events or occurrences of the day
    - **O: O**verall Health status
    - **U**: **U**pcoming possibilities and things to watch for
    - **T**: **T**asks that need to be completed prior to next handoff
    - **?**: Any questions**?**
- Your interns will be observed at least once during this rotation and be provided with feedback on your transition of responsibility. Please assist them in providing the appropriate level of detail and content for these handoffs

DukeMedicine

Internal Medicine
Residency Training
Program

2012-2013 DUKE GENERAL MEDICINE NIGHT RESIDENT ORIENTATION

Your responsibilities and goals as the night resident on Duke General Medicine have shifted to focus on fostering teamwork, maintaining clear and open lines of communication, and making sound clinical decisions. Each night resident serves an integral function to their team, and leads the critical task of ensuring that our patients have safe and effective transitions of care in the mornings and evenings. This requires precise, concise, and timely exchanges of information and a culture of teamwork and communication. The rotation also provides opportunity to continue to expand clinical skills and efficiency of care and work closely with hospital medicine faculty and assistant chief resident in the triaging of patients and management of inpatient census and patient flow.

NIGHT RESIDENT SCHEDULE:
The Duke Night Resident Schedule is generally centered on a cycle of 4 nights of duty followed by night off over a 2-3 week rotation. Transitions of care and responsibility have become decentralized and have a focus on bedside encounters for patients who are new or sick.

Day #1: NR Early
5:00 PM Meet your day team at designated handoff area. This will often be day when either the resident or interns are in clinic and will rarely have new admissions. Assist team in completion of patient care duties and receive handoff on current patients on service. Expected to have brief bedside encounter alongside day team for patients that are new to service or who are sick and anticipated to have issues overnight. Will begin admitting patients early in the evening to assist in the late afternoon/early evening peak hours (please touch base with the ACR when you arrive as often there will be an admission for you upon arrival). On many evenings, you will have a medical student with you. The student should admit the first patient with you, and that patient should go to the team (A or B) that the student is working with. Please assist the student in his workup in preparation for attending rounds in the morning and know that the student will leave by midnight.

6:00 AM Scheduled meeting with overnight Hospital Medicine Faculty and Night Residents to finalize team assignments.

7:00 AM Meet your team at designated handoff area. Provide update on overnight events of patients previously known to day team. Expected to have brief bedside

encounter alongside day team for patients that are new to service or who had significant events overnight.

Days #2 & #3: NR On

6:30 PM Meet your day team at designated handoff area. As above, facilitate completion of patient care duties and receive handoff on current patients on service with brief bedside encounters for patients who are either new to service or who are sick. Following handoffs, you will begin admitting new patients.

6:00 AM Scheduled meeting with overnight Hospital Medicine Faculty and Night Residents to finalize team assignments.

7:00 AM Morning handoff meeting with your team at designated area as above

Day #4: **NR 1010**

6:30 PM Meet Duke ACR for handoff on 1010 General Medicine Admissions Triage pager and distribution sheet. Then meet day team at designated handoff area. As above, facilitate completion of patient care duties and receive handoff on current patients on service with brief bedside encounters for patients who are new to service or who are sick. The GM12 intern will also find you in this timeframe to provide handoff on their service for overnight.

7:30-8:00 PM Meet the "Late" Day team – their NR is off that night – for handoff on their team. Facilitate interns' completion of patient care duties. Day resident will meet with Chief Resident and/or Assistant Chief Resident on weekdays for evening signout teaching rounds. Again, brief bedside encounters are encouraged for patients who are new or sick. Facilitate the "Late" team completion of clinical duties by no later than 9pm. Overnight, the 1010 Night Resident will cover their own team, the "Late" team whose NR is off, GM12, and assume responsibility for 1010 admissions triage, but will do few if any admissions (exception would be if there is a high volume of patients or bounceback admissions to those teams being covered)

6:00 AM Scheduled meeting with overnight Hospital Medicine Faculty and Night Residents to finalize team assignments.

7:00 AM Morning handoff meeting with your team and the other GM team and GM12 intern at your designated handoff area.

DESIGNATED HANDOFF AREAS:

GM1 8100 Workroom
GM2 8300 behind HUC

GM3	8100 behind HUC
GM4	Med Res Library
GM5	8300 Workroom

RESIDENT RESPONSIBILITIES:

- Each night resident is paired with one of the five day resident general medicine services GM1-5.
- On any given night, four residents are on duty.
- Three of the four night residents are covering their service at night and admit new patients to general medicine
- The fourth night resident covers their own service, the service of night resident who is off for the night, GM12, and helps triage and assign admissions as the 1010 resident.
- Several of the patients admitted overnight will likely remain on your resident GM team; however, the overnight Hospital Medicine faculty member will review admissions appropriate for distribution to hospitalist teams and often staff those admissions deemed appropriate for GM6-10 early in the evening. Final team assignments will be made at the morning meeting with all night residents and the Night Hospital Medicine faculty – **THIS MEETING IS EXTREMELY IMPORTANT TO ENSURE EFFECTIVE TRANSITION OF CARE BETWEEN NIGHT AND DAY TEAMS**, particularly on busy nights with many admissions.
- **Diligent transitions of responsibility for patient care (handoff/signout) are of utmost importance.** In addition to importance of verbal communication at handoff (see below for suggested technique), please check that the following tasks are completed at each day/night transition with new admissions
    - Patients have correct team, attending, resident, intern in CPOE orders
    - New patients have been added to eBrowser patient handoff list
    - New admission H&Ps assigned to correct attending

OVERNIGHT SUPPORT FROM HOSPITAL MEDICINE FACULTY:

Goals

1. The primary responsibility of the hospitalists working at night is to supervise and help educate the junior residents doing admissions. This includes incorporation of current literature into clinical practice and supervision for overnight procedures
2. Teaching the junior residents at night is most likely to be successful if it is based on the current patients that they are admitting. Some of the patient presentations should occur in the work rooms but we also encourage the attending and the resident to go to the bedside for some patients. Also strongly suggested is planning with the residents at the beginning of the shift how and when patients will be seen and discussed. Bedside discussion cannot happen with every admission but the group should make some effort to do this on a certain number each night. The bedside presentations could be of particularly interesting patients, significantly ill patients, and those that are going to the hospitalist service the next day. The "pace" of the night will dictate how much bedside presentations can occur.

3. The night hospitalist will work with the night 1010 resident to determine which patients should go to resident versus hospitalist teams the next morning at the 6AM meeting with all night resident.
4. The hospital medicine faculty and residents working at night should attempt to review patients admitted the previous night and address any unexpected changes or interesting cases as teaching opportunities (e.g. "follow-up rounds").
5. In case of high volume of admissions or if the night resident's "cap" in their total number of admissions the nighttime hospital medicine faculty are available to help with admissions.
6. **Scheduled meeting at 6:00am every day (this can be done in the common workroom or library)**
    a. Finalize plans for distribution of patients to resident and hospital medicine teams
    b. Following this meeting, Night Residents will be responsible for transitioning care to the resident day teams at 7am morning handoff. Any patients that are to be transitioned to the hospital medicine GM6-10 teams in the morning will be the responsibility of the night hospitalist to ensure effective transition of care at hospital medicine morning handoff. A useful way to keep track of these admissions is to print out your Admission H&P
    c. It is critical that the team census numbers are reconciled and reported on daily basis at this meeting
    d. On weekdays, the Hospital Medicine faculty member will assume responsibility of 1010 Admissions triage at completion of this meeting
    e. On weekends, the 1010 Night Resident will continue to cover 1010 admissions triage until passing off to day resident at 7am morning handoff.

DUTY HOURS:

- Residents are scheduled for less than 80 hours a week on average of service
- Duty hours should be reported at least on a weekly basis in Medhub

DAYS OFF:

- Days off are scheduled and listed on general medicine block census.
- In general, the night following time as 1010/Crosscover night resident is the day off
- On Sunday nights, residents from the 7800/9100 subspecialty night service will cover role of 1010/Crosscover resident to provide additional day off
- Adjustments in days off may occasionally be possible, but require discussion and approval by chief resident well in advance for location reporting and to ensure compliance with duty hour standards

CONFERENCES:

- There are no required conferences for the night resident rotation.
- Tell ACR about good cases, EKGs, CT's, physical findings etc., for gallops, EKG conference, Chair's, M&M.
- Medicine Noon Conferences are recorded and available on MedHub for night resident review

CRITICAL DOCUMENTATION REQUIREMENTS:

- **An initial Universal Admission Data Form (electronic H&P) must be completed (and be complete) by the resident for every admission.** The electronic document will need to be cosigned, and edited/amended by the attending physician before it is officially complete.
- The H&P database form must be complete (including pain score, functional status**,** review of symptoms)
- All verbal orders must be signed by a physician before a patient is discharged

INPATIENT PROCEDURE SERVICE:

- A trained Hospital Medicine attending will be available to supervise bedside procedures performed on patients hospitalized at Duke from 8am-6pm, 7 days per week. Night coverage is often available as well, so please contact them as needed. Please note that this is available when the service is running at capacity.
- Bedside procedures include central line placement, thoracentesis of uncomplicated effusions, paracentesis (both diagnostic and therapeutic), arthrocentesis, and lumbar puncture.
- For some of these procedures (central line placement, thoracentesis and paracentesis) the attending will be able to assist with ultrasound guidance.
- The intern/resident will still perform the procedure under the supervision of the attending.
- To contact the procedure attending, please page **970-7409**; at night the night hospital medicine faculty member may be able to assist with bedside procedures using the ultrasound

PROCEDURES:

- Must be done with supervision unless resident is certified (i.e., has met the program requirements)
- Be sure to write a procedure note (template available)
- Please use appropriate protection (including eye protection!) and sterile technique
- Any procedure involving a body fluid or needle has potential to cause an exposure
- Any procedure involving a body fluid or needle has potential to cause an exposure. If exposure occurs, please notify your supervisor and call 115 for guidance from occupational health
- ***Must perform time out and document in chart*** (two people confirm person, site, procedure)

GENERAL MEDICINE ADMISSIONS TRIAGE RESPONSIBILITIES (970-1010):

- Please see separate 1010 policy and reference form
- In brief, please realize that all parties contacting the 1010 physician are seeking assistance in some form or another, and that we are committed to providing service in a timely, professional, and collegial manner.

- Hospital medicine faculty are present around the clock to help negotiate resolutions and assist in triaging patients if questions or conflicts arise.

TRANSITIONS OF RESPONSIBILITY:

- Safe and effective handoffs are important to our patients' care.
- Handoffs are scheduled to commence at designated handoff areas at the beginning and end of every day, and with decentralization and reduction in the number of teams being covered, an emphasis is now placed on brief bedside encounter for new or sick patients.
- Model good handoff behavior
    - Use consistent system and structure to handoffs.
    - Be on time and at appropriately designated location
    - Minimize interruptions and distractions during the handoff process
    - Have the person who is accepting handoff repeat critical tasks or information (readback technique)
    - Use clear, explicit, and unambiguous language
    - Allow the person who is accepting handoff ask questions (interactivity)
    - Identify sick and new patients and strongly consider joint evaluation at bedside
- Suggested Technique – **SIGNOUT?**
    - **S**: Is this patient particularly **S**ick or DNR
    - **I**: **I**dentifying data and demographic info about patient
    - **G: G**eneral hospital course for the patient
    - **N**: **N**ew events or occurrences of the day
    - **O: O**verall Health status
    - **U**: **U**pcoming possibilities and things to watch for
    - **T**: **T**asks that need to be completed prior to next handoff
    - **?**: Any questions**?**

DukeMedicine

Department of Medicine
Hospital Medicine Program

GENERAL MEDICINE ADMISSION PAGER (970-1010) POLICY

SUMMARY:

Admissions to the Duke General Medicine service will be facilitated by a designated junior or senior medical resident or Hospital Medicine faculty member signed onto the 970-1010 functional page number. Our goals are to facilitate access and admissions, ensure that patients can receive safe and effective care on the General Medicine Service, and deliver timely and high quality care to new patients on our service.

PROCESS:

- Physicians assigned to cover the 970-1010 pager will sign onto the pager and maintain the General Medicine Admission Form which tracks expected admissions, transfers, and patients assigned to on call teams.
- Pages should be answered immediately whenever possible
- All appropriate admission requests should be assessed for possible transfer to DRH via the Duke ED - DRH transfer process
- In general, all admission requests will be granted. Exceptions require discussion and evaluation by either the lead hospitalist (970-7777) or the 1010 resident's general medicine team attending.
- Whenever possible, patient's accepted from the Duke Emergency Department should be assigned team (GM team number, attending, and resident) at the time of the first contact and slotted into appropriate space on the General Medicine Admission Form
- Patients accepted from outpatient clinics or transferring out from an intensive care unit to general ward should be noted on the back of General Medicine Admission Form and given team assignment once general ward bed is confirmed

SCHEDULE: ** All handoffs are to be done in person in DN8253. **

Monday – Friday

6:00 AM – 2:00 PM	Duke General Medicine Lead Hospitalist (970-7777)
2:00 PM – 7:00 PM	Duke Assistant Chief Resident
7:00 PM – 6:00 AM	General Medicine Night Resident

Saturday - Sunday

7:00 AM – 7:00 PM	General Medicine Resident on call
7:00 PM – 7:00 AM	General Medicine Night Resident

GENERAL TIPS:

- Patients with privacy concerns (faculty, house staff, students, nurses, etc.) should in general be on the GM-7-10 Hospital Medicine Faculty service

- For cases identified as possible non-teaching service or DRH transfer patients, the Lead Hospital Medicine attending should be paged immediately at 970-7777
- Have eBrowser open when you get called. It may help you follow along with the clinical presentation, review concerning labs, etc.
- Note important identifying information for the admissions immediately, and contact bed control (when necessary) in a timely fashion to avoid errors of omission and break downs in communication.

DUKE EMERGENCY DEPARTMENT ADMISSIONS:

- If the 1010 physician has concerns about patient safety on General Medicine, or believes the patient requires a service (i.e. surgical intervention) which cannot be provided this should be discussed with the ED physician and ED attending if necessary. If an agreement cannot be reached on appropriate disposition (ICU evaluation, etc) and safety concerns persist, the 1010 resident should contact the medical chief resident or lead hospitalist (970-7777) to discuss the case further.
- If the 1010 physician feels the patient is better served being admitted by another service they should strongly consider personally examining the patient to better advocate for their position
- Should a resident covering 1010 feel a patient does not require inpatient admission, then that resident's general medicine team attending or the lead hospitalist (970-7777) must evaluate the patient and discuss the alternative dispositions with the ED attending. Following this discussion, if decision is to discharge patient home, the evaluating attending physician will dictate a consult note
- Additional studies requested of the ED staff should be limited to necessary/urgent studies which may change disposition. The ED's main role is to initiate a medical evaluation, stabilize patients, and triage care appropriately, not to complete the workup.
- To effectively transition care to General Medicine, the 1010 physician should call the admitting team with appropriate details including the contact information for ED treating physicians

SUBSPECIALTY SERVICES:

- Duke Cardiology (CHF, DHP, EP, Transplant, General Cards), Pulmonary (Transplant, General), Neurology (Epilepsy, General), and Oncology (9100 leukemia/lymphoma, 9300 solid tumor malignancy) have inpatient services separate from general medicine staffed by members of each division
- Most renal transplant patients are admitted to the General Medicine Service with Nephrology consultation. A minority of patients with apparent need for hospitalization related to their surgery can be admitted to a combined Medicine-Surgery service on 2100/2300 staffed by surgical residents and attending transplant surgeon and nephrologist. Direct questions to attending nephrologist or transplant surgeon on call.
- There is no longer a distinct inpatient renal service for dialysis patients followed by Duke Nephrology. These patients will now be admitted to general medicine service (970-1010)

TRANSFER CENTER CALLS: 681-3440

- All transfer center calls will be routed to the Duke General Medicine Lead Hospitalist at 970-7777.

ICU TRANSFERS:

- If you are concerned about a patient's stability or appropriateness, you can see the patient first before accepting them to General Medicine.
- Once patient is accepted call bed control (681-4300) to request a floor bed.
- Don't assign a team until the patient has a floor bed – it can sometimes take a while (days) to get a bed and until then, the unit continues caring for the patient.
- When a bed is available, bed control will call and ask for a team assignment. At that time, ask the ICU resident to contact the appropriate General Medicine team to communicate care information.

TRANSFERS FROM OTHER SERVICES:

- Transfers from other services require an initial consultation or clinical review.
- Complex patients often are better served on the General Medicine Service.
- The General Medicine Consult Service (970-7777) is available to non-medicine services and can often help to assist managing medical problems. Many patients have been followed by General Medicine consults already. In general, contact the Hospitalist covering consults before accepting patients in transfer to our service.
- If you get called in the middle of the night regarding a transfer from another service and you are in doubt about what needs to happen, you can always defer until the next morning to have the lead hospitalist, medical chief resident, or ACR investigate.
- The hospitalists will not accept patients to the General Medicine teaching services (GM1-6), but may call 1010 to request this on occasion.

DUKE MEDICINE CLINICS:

- Duke Department of Medicine outpatient physicians requesting admission to General Medicine should provide the 1010 physician with a brief clinical presentation and rationale for admission.
- Non Department of Medicine outpatient physicians requesting admission to Duke General Medicine need approval for their request from the Duke General Medicine Lead Hospitalist (970-7777)
- When you accept patients from clinic, decide with the referring physician whether the patient should wait in clinic, go home and wait for a call, go to Duke North admissions (front lobby) while waiting for a bed, or if they should proceed to the ED for stabilization and management during times of limited bed capacity.
    - Decision largely depends on expected wait time and patient acuity. Patients who require monitoring or ongoing assessments/treatments must remain in a clinical care setting (clinic) or go to the ED if a bed is not available for direct admission.

    - For patients waiting in clinic or at home, bed reservations needs a phone number to call them when a bed is ready
- Call bed reservations at 620-5275 to request a bed for patients in clinic after speaking with the clinic physician. Please give the name of the lead hospitalist (970-7777) as name of accepting physician
- Note the clinical details for the patient on the back of the General Medicine Admission Form in the provided spaces
- Once a general ward bed has been assigned to the patient by bed reservations, the patient can be assigned to a team

DukeMedicine

Department of Medicine
Hospital Medicine Program

Duke General Medicine:
Effective Handoffs and Physician Sign Out

Speakers systematically overestimate how well their messages are understood by listeners!

Communication strategies during successful hand-offs in care:

- Standardize: use the same order of data elements or template for communication
- Update information daily and provide accurate information to your colleagues
- Limit interruptions
- Face to face verbal updates with interactive questioning are most effective
- Structure: use “read back” to ensure accuracy of most critical issues

A word of caution on technology: BWH study of computerized sign-out, replicated with different system at UW – IT solutions alone cannot substitute for a successful human communication encounter.

Strategies for effective verbal communication:

- Use “If/then” scenarios to provide anticipatory guidance to care givers less familiar with the patient
- Highlight “To do” tasks which need to be accomplished
- Use precise language and avoid ambiguity

Framework for verbal sign-out: "SIGNOUT?"

S	**Sick or DNR?**	OK, this is our sickest patient, and he's full code…
I	**Identifying data**	Mr. Jones is a 77 year old with a right middle lobe pneumonia
G	**General hospital course**	He came in a week ago hypoxic and hypotensive, but improved rapidly with moxifloxacin
N	**New events of the day**	Today, he spiked to 39.5 and white count bumped from 8 to 14. Portable chest x-ray was improved from admission. We sent blood and urine cultures. UA was negative, but his IV site looked red so we started vanc
O	**Overall health status**	Right now he is comfortable on 2L O2, saturations are 98%, and he is afebrile.
U	**Upcoming possibilities**	If he starts to drop his blood pressure, use NS bolus and start NS at 125cc/hr and have a low threshold for talking with the MICU for possible sepsis.
T	**Tasks to complete overnight with plan and rationale**	I'd like you to look in on him around midnight and make sure his vital signs and exam are unchanged. I don't expect any culture results back tonight, so no need to check them.
?	**Any questions?**	Any questions?

Written sign-out: using Physician Hand-off utility on eBrowser

- All patients should be included on your list
  - Even those who are discharged that day
  - Maintain a list of your patients who have been transferred to the ICU as well
- Update daily – make time to do this as a priority
  - Patient demographics, bed location, allergies, and medications automatically update
  - **General hospital course, events of the day, and any change in advance directives must be updated by the physician daily**
- Information should mirror your verbal hand-off to enhance the efficacy of your verbal communication and limit notes the listener will need to take
- Avoid ambiguity:
  - "NPO after midnight" – which midnight and why NPO?
  - "ERCP planned tomorrow" - ??
- Always:
  - Document advance directives
  - Use dates for procedures, NPO, planned discharges
  - For "To do" items, give guidance about what to do with the results and baseline for comparison ("Check HCT, last 6-28 at 9am 28, transfuse 1u PRBC if < 24")

Feedback on hand-offs:

- The most effective feedback on hand-offs comes from peers
- Each daily hand-off is an opportunity to reinforce effective communication ("That was really helpful and clear for me") or provide constructive feedback ("It would be easier for me to follow if we used the same order of information for each patient…")

Hand-offs are more than just a transfer of content, but are also a transfer of professional responsibility. Remember, after you accept a hand-off every patient is now your patient.

Ward Rounds

Reflection: Were you taught how to ward round? How did you learn this important skill?

Conducting ward rounds is a complex task requiring:

- Leadership skills
- Communication skills
- Team-work skills
- Time management skills
- Clinical skills
- Medical knowledge
- Professionalism

Literature supports the need for better preparation of trainees with respect to ward rounds:

- Physicians view the MAR only 65-70% of the time
- Physical examination performed on only 44% of patients
- The deficit most commonly perceived by patients during the hospital stay is poor communication between patients, nurses, and physicians

Reflection: Do you have a structure, pattern, or model for ward rounds?

Figure outlines suggested rounding model. Requires:

- Planning and organization
- Control and leadership
- Regimented process
- Clear communication
- Time management
- Think-out-loud teaching

Reflection: How is the new system challenging your abilities?

Reflection: What is working for you? What is not working for you?

Action: What adaptations would you like to make? What would you like to accomplish over the next two weeks?

Tip: Have team together for 10 minutes in work room to state rounding

Setting the Stage

- Clarify participants and their ability to participate
- Clarify the need for team discussion before patient rounds
- Clarify organizational issues and issues of importance

Tip: Notice your posture: *can everyone hear you?* How did plan change based on in-room encounter?

Patient Rounds

- Alert the nurse
- The one-liner
- What happened yesterday? Overnight?
- Review of vital signs, MAR, chart notes
- Summarize agenda before entering room
- Patient encounter
  - Open-ended questions
  - Elicit patient agenda
  - Physical exam
  - Summarize short term and long term plan for the patient
  - Share daily goals with nurse
  - Ensure patient understanding
  - Close with an open-ended question
- Summarize and delegate

At the end of each patient encounter, you should have a PARTIAL NOTE WRITTEN, A PLAN FOR THE DAY and COMMUNI-CATION WITH NURSING

Post-Rounds

- Summarize responsibilities, timelines and outstanding issues
- Check for understanding
- Evaluate and reflect on the process

8100 & 8300 STEP DOWN

There is now limited capacity for GenMed stepdown status on wards 8100 and 8300.

The current intention is to use this in true stepDOWN capacity and not as stepUP for very sick patients being admitted from the emergency room. Before accepting a patient from the ER to stepdown status, please discuss with ACR, chief resident (970-9648), or lead hospitalist (970-7777).

Currently, the charge nurses on 81/83 are trying to identify patients on the wards who meet stepdown criteria. You may be asked to change the CPOE order to stepdown. Alternatively, you may be asked to downgrade the patient's status to routine care if stepdown criteria are no longer met. Keep in mind that it is illegal (medicare fraud) to keep someone on stepdown status when they no longer meet criteria (the cost difference is about $1000/day).

Communicate clearly with the charge nurses on 81/83 if you would like to put a patient on stepdown status. As capacity is limited by bed availability and staffing, please do not assume that stepdown will be available.

General Guidelines:

These guidelines are intended to help determine if there are increased nursing requirements and patient acuity level on 8100 and 8300. A patient may be considered for step down status if he/she meets the following criteria. In all cases patient safety is the main focus; patients will be transferred to the ICU if they require a higher level of care than can be safely provided on 8100/8300 based on patient acuity or nursing competence.

Key Components:

☐☐The charge nurse, in collaboration with unit management and physician, may place a patient in step down status when criteria is met.
☐☐An order must be written to change the patient to step down status in the chart, and the appropriate care level changed in DHIS.
☐☐Assignments will continue to be made and reassessed based on patient acuity.

Patients meet step down criteria if they meet *at least 2 of the following:*

Drugs (Non-Titrating)

☐☐Amiodarone (Cordarone)
☐☐Cardiazem (Diltiazem)
☐☐Dobutamine (Dobutrex)
☐☐Dopamine (Intropon)
☐☐Labeletalol (Normodyne)

General Criteria

☐☐Nursing assessment q4 hrs or more or problem focused assessment q2hrs or more
☐☐Vital signs q2 hrs or more
☐☐4 or more IV's
☐☐Active DT's or substance withdrawal
☐☐Acute delirium
☐☐Hourly fingersticks for insulin adjustments
☐☐CAPD exchanges q2hrs
☐☐Skin care requiring greater than 30 min/ 8 hours
☐☐Rapid volume replacement to maintain stability
☐☐Respiratory care(trach suctioning, pulmonary toilet, chest PT) q 2hrs or more
☐☐I&O q 4 hrs or more
☐☐SBP at least 90 mmHg or 15% of patient's baseline
☐☐HR <50 or >140 beats/minute and able to be maintained with non-titrating drugs
☐☐FiO2 less or equal to 60% with O2 saturation of 88%
☐☐Inability to maintain adequate oxygenation without supplemental device (nasal Bipap, Cpap, etc)
    - o Requires chronic full-face B-PAP
    - o Presence of tracheotomy

Step Down Requirements

☐☐Vital Signs q4 hrs
☐☐Focus documentation every shift to support need for step down status

PGY1 GenMed

Version Mar 10 2009

Rotation Map for Interns- General Medicine Wards

Goals	Objectives	Teaching Methods	Evaluation Methods/Tools	Core Competencies	Resources
I. Interns will develop the skills to evaluate, diagnose and manage patients requiring hospitalization on the Internal Medicine service under the supervision of residents and teaching attending physicians	1. Recognize common clinical presentations and cardinal manifestations of disease to formulate **initial clinical impression and a prioritized patient care plan**	Supervised bedside encounters Call duty with residents Work rounds with resident Attending rounds Intern report Noon Conference Grand Rounds	Attending observation Attending→intern evaluation 360° evaluation Medical record review Intern report attendance log Noon conference attendance log	Patient Care (PC) Medical Knowledge (MK) Practice-Based Learning (PBL) Interpersonal & Communication Skills (ICS) Systems- Based Practice (SBP) Professionalism (P)	Core curriculum lectures and iTunes Library (didactic noon conference curriculum) Self-directed learning database (for each specific Internal Medicine discipline) Common medical conditions (for each specific Internal Medicine discipline) Individualized learning plan
	2. Demonstrate **comprehensive evaluation, presentation, documentation and decision-making skills** including history taking, physical examination, laboratory evaluation, diagnosis and patient management	Supervised bedside encounters Work rounds with resident Call duty with residents Attending rounds Intern report Noon Conference Grand Rounds	Attending observation Attending →intern evaluation 360° evaluation Medical record review Intern report attendance log Noon conference attendance log	PC MK PBL ICS SBP P	
	3. Effectively **employ medical knowledge to manage patients** at the time of admission and during hospitalization under the supervision of resident and attending physician	Supervised bedside encounters Work rounds with resident Call duty with residents Attending rounds Intern report Noon Conference Grand Rounds	Attending observation Attending→intern evaluation 360° evaluation Medical record review Intern report attendance log Noon conference attendance log	PC MK PBL ICS SBP P	
	4. Appropriately select, order and interpret **laboratory tests** and other **ancillary resources** necessary for the evaluation and management of inpatients	Supervised bedside encounters Work rounds with resident Call duty with residents Attending rounds Intern report Noon Conference Grand Rounds	Attending observation Attending→intern evaluation 360° evaluation Medical record review Intern report attendance log Noon conference attendance log	SBP PC MK PBL	
	5. Recognize the **requirement for consultation** from another specialty or a subspecialty service and learn to apply recommendations appropriately to the care of the patients	Supervised bedside encounters Work rounds with resident Call duty with residents Attending rounds Intern report Noon Conference Grand Rounds	Attending observation Attending→intern evaluation 360° evaluation Medical record review	PC MK PBL ICS SBP P	

PGY1 GenMed

Version Mar 10 2009

	6. Recognize the appropriate timing of and learn to carry out, when indicated, **end-of-life care/difficult situation discussions** with patients and their families under supervision of the attending physician	Supervised bedside encounters Attending rounds	Attending observation Attending→intern evaluation	PC MK P	
II. Interns will learn to perform diagnostic and therapeutic procedures as indicated for the care of their patients	Plan and perform in a safe manner the appropriate **diagnostic and therapeutic procedures** necessary for the evaluation and management of inpatients and learn to obtain informed consent	Observation of procedure Perform procedures under direct supervision of resident and attending	Attending observation Attending→intern evaluation Medical records review Procedure log	PC MK SBP P	Duke Procedures Videopedia
III. Interns will develop the skills to teach medical students	Participate actively in all the **teaching activities directed towards medical students** on the team and demonstrate proficiency in teaching	Observation of resident/attending Bedside encounters with students Work rounds with students Call duty with students Attending rounds	360° evaluation Attending observation Attending→intern evaluation	MK ICS P	
IV. Interns will learn to effectively employ interpersonal and communication skills in a professional manner	Demonstrate **exemplary attitude** and develop **effective communication skills** towards patients, their families, colleagues and members of the multidisciplinary medical team including support staff, and learn to apply these skills to improve patient care and own performance by asking supervisors for feedback	Observation of resident/attending Bedside patient encounters Case presentations Meetings with patients' families Multidisciplinary rounds Intern report	Attending observation Attending→intern evaluation 360° evaluation Medical record review	PC ICS SBP P	

See full-size tables after Appendix.

PGY2 GenMed

Version Mar 10 2009

Rotation Map for Junior Assistant Residents- General Medicine Wards

Goals	Objectives	Teaching Methods	Evaluation Methods/Tools	Core Competencies	Resources
I. JARs will develop and apply the skills to evaluate, diagnose and manage patients requiring hospitalization on the Internal Medicine service	1. Recognize common clinical presentations and cardinal manifestations of disease to formulate a focused differential diagnosis, **initial clinical impression and a prioritized patient care plan**	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→JAR evaluation 360° evaluation Medical record review Resident report attendance log Noon conference attendance log	Patient Care (PC) Medical Knowledge (MK) Practice-Based Learning (PBL) Interpersonal & Communication Skills (ICS) Systems- Based Practice (SBP) Professionalism (P)	Core curriculum lectures and iTunes Library (didactic noon conference curriculum) Self-directed learning database (for each specific Internal Medicine discipline) Common medical conditions (for each specific Internal Medicine discipline) "How to be a JAR" presentation by Program Director Individualized learning plan
	2. Demonstrate **comprehensive evaluation, presentation, documentation and patient management skills**, including history taking, physical examination, laboratory evaluation, diagnosis and patient care, including longitudinal care plan to transition to outpatient care	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→JAR evaluation 360° evaluation Medical record review Resident report attendance log Noon conference attendance log	PC MK PBL ICS SBP P	
	3. Effectively **apply medical knowledge to manage patients** at the time of admission and during hospitalization under the supervision of attending physician	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→JAR evaluation 360° evaluation Medical record review Resident report attendance log Noon conference attendance log	PC MK PBL ICS SBP	
	4. Appropriately select, order and interpret **laboratory tests** and utilize **other ancillary resources** necessary for the evaluation and management of inpatients	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→JAR evaluation 360° evaluation Medical record review Resident report attendance log Noon conference attendance log	SBP PC MK PBL	
	5. Recognize the **appropriate requirement for consultation** from another specialty or a subspecialty service, communicate effectively with consultants, and apply recommendations appropriately to the care of patients	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→JAR evaluation 360° evaluation Medical record review	PC MK PBL ICS SBP P	

PGY2 GenMed

Version Mar 10 2009

	6. Recognize the appropriate timing of and learn to carry out when indicated, **end-of-life care and difficult situation discussions** with patients and their families	Supervised bedside encounters Attending rounds	Attending observation Attending→JAR evaluation	PC MK P	
II. JARs will learn and demonstrate the skills to perform diagnostic and therapeutic procedures as indicated	Select, plan and perform in a safe manner the **appropriate diagnostic and therapeutic procedures** necessary for the evaluation and management of inpatients and obtain informed consent prior to procedures	Observation of procedure Perform procedure under supervision of Chief resident or attending Review teaching videos	Attending observation Attending→JAR evaluation Medical record review Procedure log	PC MK SBP P	Duke Procedures Videopedia
III. JARs will develop the skills to teach more junior trainees including interns and medical students as well as peers in the capacity of the General Medicine team leader	1. Acquire the skills to **effectively teach interns and medical students** on the patient care team as well as peers rotating through General Medicine, including giving constructive feedback to more junior trainees	Observation of attending Observation of Chief residents Bedside encounters with interns Bedside encounters with students Work rounds with interns/students Call duty with interns/students Attending rounds Resident report Sign-out rounds with Chief residents Attendance of SAR talks	360° evaluation Attending observation Attending→JAR evaluation Sign-out rounds with Chief residents "Clinical Teaching Workshop"	MK ICS P	"Clinical Teaching Workshop" for JARs
	2. Learn to function as an effective **General Medicine team leader**, applying leadership skills to teach and to deliver excellent patient care	Observation of attending Observation of Chief residents Bedside encounters with interns Bedside encounters with students Work rounds with interns/students Call duty with interns/students Attending rounds	360° evaluation Attending observation Attending→JAR evaluation Sign-out rounds with Chief residents Clinical teaching workshop	PC MK ICS SBP P	
IV. JARs will effectively utilize interpersonal and communication skills in a professional manner and apply these skills to improve patient care	Demonstrate **exemplary attitude** and develop **effective communication skills** towards patients, their families, peers, colleagues and members of the multidisciplinary medical team including support staff, and learn to apply these skills to improve patient care and own performance by asking supervisors for feedback and by providing junior trainees with constructive feedback	Observation of attending Observation of Chief residents Bedside patient encounters Case presentations Meetings with patients' families Multidisciplinary rounds Resident morning report	Attending observation Attending→JAR evaluation 360° evaluation Medical record review Clinical Teaching Workshop	PC ICS SBP P	

See full-size tables after Appendix.

PGY3 GenMed

Version Mar 10 2009

Rotation Map for Senior Assistant Residents- General Medicine Wards

Goals	Objectives	Teaching Methods	Evaluation Methods/Tools	Core Competencies	Resources
I. SARs will demonstrate the skills and proficiency required to independently evaluate, diagnose and manage patients requiring hospitalization on the Internal Medicine service	1. Recognize common clinical presentations and cardinal manifestations of disease to consider a broad differential diagnosis, formulate **initial** clinical impression, and employ a prioritized patient care plan	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→SAR evaluation 360° evaluation Medical record review Resident report attendance log Noon conference attendance log	Patient Care (PC) Medical Knowledge (MK) Practice-Based Learning (PBL) Interpersonal & Communication Skills (ICS) Systems- Based Practice (SBP) Professionalism (P)	Core curriculum lectures and iTunes Library (didactic noon conference curriculum) Self-directed learning database (for each specific Internal Medicine discipline) Common medical conditions (for each specific Internal Medicine discipline) Individualized learning plan
	2. Demonstrate **independent and comprehensive** evaluation, presentation, documentation and patient management skills, including history taking, physical examination, laboratory evaluation, diagnosis and patient care, including longitudinal care plan to transition to outpatient care	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→SAR evaluation 360° evaluation Medical record review Resident report attendance log Noon conference attendance log	PC MK PBL ICS SBP P	
	3. Effectively **apply medical knowledge to independently manage patients** at the time of admission and during hospitalization and exhibit the ability for independent decision-making and patient care plans for a larger number of patients	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→SAR evaluation 360° evaluation Medical record review Resident report attendance log Noon conference attendance log	PC MK PBL ICS SBP	
	4. Appropriately select, order and interpret **laboratory tests** and utilize other **ancillary resources** in an independent manner necessary for the evaluation and management of inpatients	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→SAR evaluation 360° evaluation Medical record review Resident report attendance log Noon conference attendance log	SBP PC MK PBL	
	5. Recognize the **appropriate requirement for consultation** from another specialty or a subspecialty service , communicate effectively with consultants, and apply recommendations appropriately to the care of patients	Bedside patient encounters Attending rounds Sign-out rounds with Chief residents Resident morning report Noon Conference Grand Rounds	Attending observation Attending→SAR evaluation 360° evaluation Medical record review	PC MK PBL ICS SBP P	

PGY3 GenMed

Version Mar 10 2009

	6. Recognize the appropriate timing of and learn to carry out when indicated, **end-of-life care and difficult situation discussions** with patients and their families	Supervised bedside encounters Attending rounds	Attending observation Attending→SAR evaluation	PC MK P	
II. SARs will demonstrate the skills to safely and independently perform diagnostic and therapeutic procedures and teach junior trainees as needed	Perform the **appropriate diagnostic and therapeutic procedures** necessary for the evaluation and management of inpatients in a safe manner, obtain informed consent prior to procedures and teach junior trainees	Observation of procedure Perform procedure under supervision of Chief resident and attending Review teaching videos	Attending observation Attending→SAR evaluation Medical record review Procedure log	PC MK SBP P	Duke Procedures Videopedia
III. SARs will effectively teach more junior colleagues and peers including interns and medical students in the capacity of the General Medicine team leader	1. Demonstrate **proficiency in teaching junior trainees** including interns and medical students on the team, as well as peers and colleagues during scholarly activities, including giving constructive feedback to more junior trainees	Observation of attending Observation of Chief residents Bedside encounters with interns Bedside encounters with students Work rounds with interns/students Call duty with interns/students Attending rounds Noon conferences	360° evaluation Attending observation Attending→SAR evaluation Sign-out rounds with Chief residents Clinical teaching workshop	MK ICS P	SAR talk Clinico-pathologic conferences
	2. Function as an **effective General Medicine team leader**, applying leadership skills to teach and to deliver excellent patient care	Observation of attending Observation of Chief residents Bedside encounters with interns Bedside encounters with students Work rounds with interns/students Call duty with interns/students Attending rounds	360° evaluation Attending observation Attending→SAR evaluation Sign-out rounds with Chief residents Clinical teaching workshop	PC MK ICS SBP P	
IV. SARs will effectively utilize interpersonal and communication skills in a professional manner and, in doing so, improve patient care and set an example to junior trainees on the team	Demonstrate **exemplary attitude** and **effective communication skills** towards patients, their families, colleagues and members of the multidisciplinary medical team including support staff, and learn to apply these skills to improve patient care and own performance by asking supervisors for feedback and by providing junior trainees with constructive feedback	Observation of attending Observation of Chief residents Bedside patient encounters Case presentations Meetings with patients' families Multidisciplinary rounds Resident morning report	Attending observation Attending→SAR evaluation 360° evaluation Medical record review Clinical Teaching Workshop	PC ICS SBP P	

See full-size tables after Appendix.

Evaluation Form

medhub

Printed on Jul 22, 2010

Internal Medicine Evaluation: Faculty of Trainee

Evaluator: _____

Evaluation of: _____

Date: _____

Thank you for serving as attending for our trainees. Your feedback as to their performance on this rotation is considered very important. As you complete this evaluation please review and consider the curriculum and rotation goals and objectives which can be accessed from your MedHub home page.

Trainees should be scored in comparison to others at the same level of training (e.g. Intern, JAR, or SAR).

1) Assesment based on:*
- ☐ < 1 Week of contact
- ☐ ~1 Week of Contact
- ☐ ~2 Weeks of Contact
- ☐ ~3 Weeks of Contact
- ☐ ~4+ Weeks of Contact

2) Contact with resident:*
- ☐ Direct Observation with Patient
- ☐ Resident Presentation
- ☐ Review of Records
- ☐ Collective Feedback
- ☐ Other

RATING SCALE

0 (NA) - Insufficient Contact to Judge - Not Applicable

1 (UNSATISFACTORY) - Does NOT meet most objectives and MANY areas for improvement.

2 (EMERGING COMPETENCY) - Meets MOST objectives but SEVERAL major areas for improvement

3 (AT EXPECTED COMPETENCY) - Meets ALL objectives with SOME areas for improvement and exceeds in SOME areas (MOST MERIT THIS RATING)

4 (FAR ABOVE EXPECTED COMPETENCY) - Meets ALL objectives and exceeds in ALL areas (functions far above level of training in all domains)

PATIENT CARE
What the Resident Does

ACGME: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health

	N/A	UNSATISFACTORY	EMERGING COMPETENCY	AT EXPECTED COMPETENCY	FAR ABOVE EXPECTED COMPETENCY
	0	1	2	3	4
3) Score:*	☐	☐	☐	☐	☐

The resident's strengths in PATIENT
- ☐ Performing and interpreting comprehensive physical exams
- ☐ Identifying problems and developing a prioritized differential diagnosis

CARE include (select all that apply):
- ☐ Developing a diagnostic work-up and treatment plan
- ☐ Monitoring patients and altering the treatment plan as data or patient needs change
- ☐ Effectively integrating evidence-based medicine, expert opinion, and personal judgment in decisions
- ☐ Efficiently managing multiple patients (multitasking)
- ☐ Recognizing, assessing, and stabilizing critically ill patients
- ☐ Procedural competency (including informed consent)
- ☐ Providing services aimed at prevention and health maintenance
- ☐ Coordinating care with other health care professionals and managing patient care transitions

---

The resident's areas for improvement in PATIENT CARE include (select all that apply):
- ☐ Performing and interpreting comprehensive physical exams
- ☐ Identifying problems and developing a prioritized differential diagnosis
- ☐ Developing a diagnostic work-up and treatment plan
- ☐ Monitoring patients and altering the treatment plan as data or patient needs change
- ☐ Effectively integrating evidence-based medicine, expert opinion, and personal judgment in decisions
- ☐ Efficiently managing multiple patients (multitasking)
- ☐ Recognizing, assessing, and stabilizing critically ill patients
- ☐ Procedural competency (including informed consent)
- ☐ Providing services aimed at prevention and health maintenance
- ☐ Coordinating care with other health care professionals and managing patient care transitions

---

MEDICAL KNOWLEDGE
What the Resident Knows

ACGME: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of knowledge to patient care.

	N/A	UNSATISFACTORY	EMERGING COMPETENCY	AT EXPECTED COMPETENCY	FAR ABOVE EXPECTED COMPETENCY
	0	1	2	3	4
4) Score*	☐	☐	☐	☐	☐

The resident's strengths in MEDICAL KNOWLEDGE include (select all that apply):
- ☐ Understanding of basic pathophysiology and the mechanisms of disease
- ☐ Ability to apply knowledge to a clinical scenario
- ☐ Ability to incorporate knowledge from prior patient encounters to future patients
- ☐ Ability to teach (students, peers, and/or patients and families)

The resident's areas for improvement in MEDICAL KNOWLEDGE include (select all that apply):
- ☐ Understanding of basic pathophysiology and the mechanisms of disease
- ☐ Ability to apply knowledge to a clinical scenario
- ☐ Ability to incorporate knowledge from prior patient encounters to future patients
- ☐ Ability to teach (students, peers, and/or patients and families)

PRACTICE-BASED LEARNING AND IMPROVEMENT
How the Resident Gets Better

ACGME: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

	N/A	UNSATISFACTORY	EMERGING COMPETENCY	AT EXPECTED COMPETENCY	FAR ABOVE EXPECTED COMPETENCY

	0	1	2	3	4
5) Score*	☐	☐	☐	☐	☐

The resident's strengths in PRACTICE-BASED LEARNING AND IMPROVEMENT include (select all that apply):

- ☐ Understanding the limitations in his/her knowledge and seeking guidance when needed
- ☐ Seeking and accepting performance feedback
- ☐ Willingness to seek out answers to what he/she does not know
- ☐ Utilizing information technology in decision-support and self-improvement
- ☐ Modifying practice based on his/her learning (e.g. patient safety, quality, error reduction)

The resident's areas for improvement in PRACTICE-BASED LEARNING AND IMPROVEMENT include (select all that apply):

- ☐ Understanding the limitations in his/her knowledge and seeking guidance when needed
- ☐ Seeking and accepting performance feedback
- ☐ Willingness to seek out answers to what he/she does not know
- ☐ Utilizing information technology in decision-support and self-improvement
- ☐ Modifying practice based on his/her learning (e.g. patient safety, quality, error reduction)

INTERPERSONAL & COMMUNICATION SKILLS
How the Resident Interacts With Others

ACGME: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates

	N/A	UNSATISFACTORY	EMERGING COMPETENCY	AT EXPECTED COMPETENCY	FAR ABOVE EXPECTED COMPETENCY
	0	1	2	3	4
6) Score*	☐	☐	☐	☐	☐

The resident's strengths in INTERPERSONAL & COMMUNICATION SKILLS include (select all that apply):

- ☐ Establishes rapport with patients from a variety of backgrounds
- ☐ Communicates complex diagnostic and therapeutic plans to patients and families in layman's terms
- ☐ Manages difficult encounters or discussions of difficult issues with sensitivity and caring
- ☐ Uses effective listening, narrative and non-verbal skills to elicit and provide information
- ☐ Medical records are legible, pertinent and organized and also completed in a timely manner
- ☐ Provides thorough, succinct oral presentation
- ☐ Works effectively as the leader of, or member of, the health care team
- ☐ Communicates effectively with consultants and/or ancillary staff

The resident's areas for improvement in INTERPERSONAL & COMMUNICATION SKILLS include (select all that apply):

- ☐ Establishes rapport with patients from a variety of backgrounds
- ☐ Communicates complex diagnostic and therapeutic plans to patients and families in layman's terms
- ☐ Manages difficult encounters or discussions of difficult issues with sensitivity and caring
- ☐ Uses effective listening, narrative and non-verbal skills to elicit and provide information
- ☐ Medical records are legible, pertinent and organized and also completed in a timely manner
- ☐ Provides thorough, succinct oral presentation
- ☐ Works effectively as the leader of, or member of, the health care team
- ☐ Communicates effectively with consultants and/or ancillary staff

PROFESSIONALISM
How the Resident Acts

ACGME: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical

principles, and sensitivity to a diverse patient population.

	N/A	UNSATISFACTORY	EMERGING COMPETENCY	AT EXPECTED COMPETENCY	FAR ABOVE EXPECTED COMPETENCY
	0	1	2	3	4
7) Score*	☐	☐	☐	☐	☐

The resident's strengths in PROFESSIONALISM include (select all that apply):
- ☐ Demonstrates respect and compassion for all patients
- ☐ Dedicated to the needs of patients and society
- ☐ Respects patient confidentiality
- ☐ Able to assess and obtain informed consent
- ☐ Honesty and trustworthiness
- ☐ Punctual with prompt follow-up on assigned tasks and patient care issues (e.g. pages, abnormal labs)
- ☐ Acknowledges errors and mistakes
- ☐ Shows regard for the opinions and skills of colleagues
- ☐ Compliance with departmental policies (e.g. duty hours, chart completion)

The resident's areas for improvement in PROFESSIONALISM include (select all that apply):
- ☐ Demonstrates respect and compassion for all patients
- ☐ Dedicated to the needs of patients and society
- ☐ Respects patient confidentiality
- ☐ Able to assess and obtain informed consent
- ☐ Honesty and trustworthiness
- ☐ Punctual with prompt follow-up on assigned tasks and patient care issues (e.g. pages, abnormal labs)
- ☐ Acknowledges errors and mistakes
- ☐ Shows regard for the opinions and skills of colleagues
- ☐ Compliance with departmental policies (e.g. duty hours, chart completion)

SYSTEMS-BASED PRACTICE
How the Resident Works Within the System

ACGME: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

	N/A	UNSATISFACTORY	EMERGING COMPETENCY	AT EXPECTED COMPETENCY	FAR ABOVE EXPECTED COMPETENCY
	0	1	2	3	4
8) Score*	☐	☐	☐	☐	☐

The resident's strengths in SYSTEMS-BASED PRACTICE include (select all that apply):
- ☐ Advocates for high quality patient care
- ☐ Guides patients through the system of care
- ☐ Uses local and/or institutional resources to assess, coordinate and/or improve patient care
- ☐ Employs cost-effective awareness in care plan and minimizes unnecessary care (e.g. testing)

The resident's areas for improvement in SYSTEMS-BASED PRACTICE include (select all that apply):
- ☐ Advocates for high quality patient care
- ☐ Guides patients through the system of care
- ☐ Uses local and/or institutional resources to assess, coordinate and/or improve patient care
- ☐ Employs cost-effective awareness in care plan and minimizes unnecessary care (e.g. testing)

OVERALL SCORE

Please select one score that represents the resident's overall peformance on this rotation.

	N/A	UNSATISFACTORY	EMERGING COMPETENCY	AT EXPECTED COMPETENCY	FAR ABOVE EXPECTED COMPETENCY
	0	1	2	3	4
9) OVERALL SCORE:*	☐	☐	☐	☐	☐

10) ADDITIONAL COMMENTS _____

11) I HAVE DISCUSSED THE EVALUATION WITH THE TRAINEE:* ☐ Yes ☐ No

Mini-Clinical Evaluation Exercise (CEX)

Evaluator:_____ Date:_____

Complexity: ☐ Low ☐ Moderate ☐ High

Focus: ☐ Data gathering ☐ Diagnosis ☐ Therapy ☐ Counseling

1. Medical interviewing (☐ Not observed)

1 2 3	4 5 6	7 8 9
UNSATISFACTORY	SATISFACTORY	SUPERIOR

2. Physical Examination Skills (☐ Not observed)

1 2 3	4 5 6	7 8 9
UNSATISFACTORY	SATISFACTORY	SUPERIOR

3. Humanistic Qualities/Professionalism (☐ Not observed)

1 2 3	4 5 6	7 8 9
UNSATISFACTORY	SATISFACTORY	SUPERIOR

4. Clinical judgment (☐ Not observed)

1 2 3	4 5 6	7 8 9
UNSATISFACTORY	SATISFACTORY	SUPERIOR

5. Counseling Skills (☐ Not observed)

1 2 3	4 5 6	7 8 9
UNSATISFACTORY	SATISFACTORY	SUPERIOR

6. Organization/Efficiency (☐ Not observed)

1 2 3	4 5 6	7 8 9
UNSATISFACTORY	SATISFACTORY	SUPERIOR

7. Overall Clinical Competence (☐ Not observed)

1 2 3	4 5 6	7 8 9
UNSATISFACTORY	SATISFACTORY	SUPERIOR

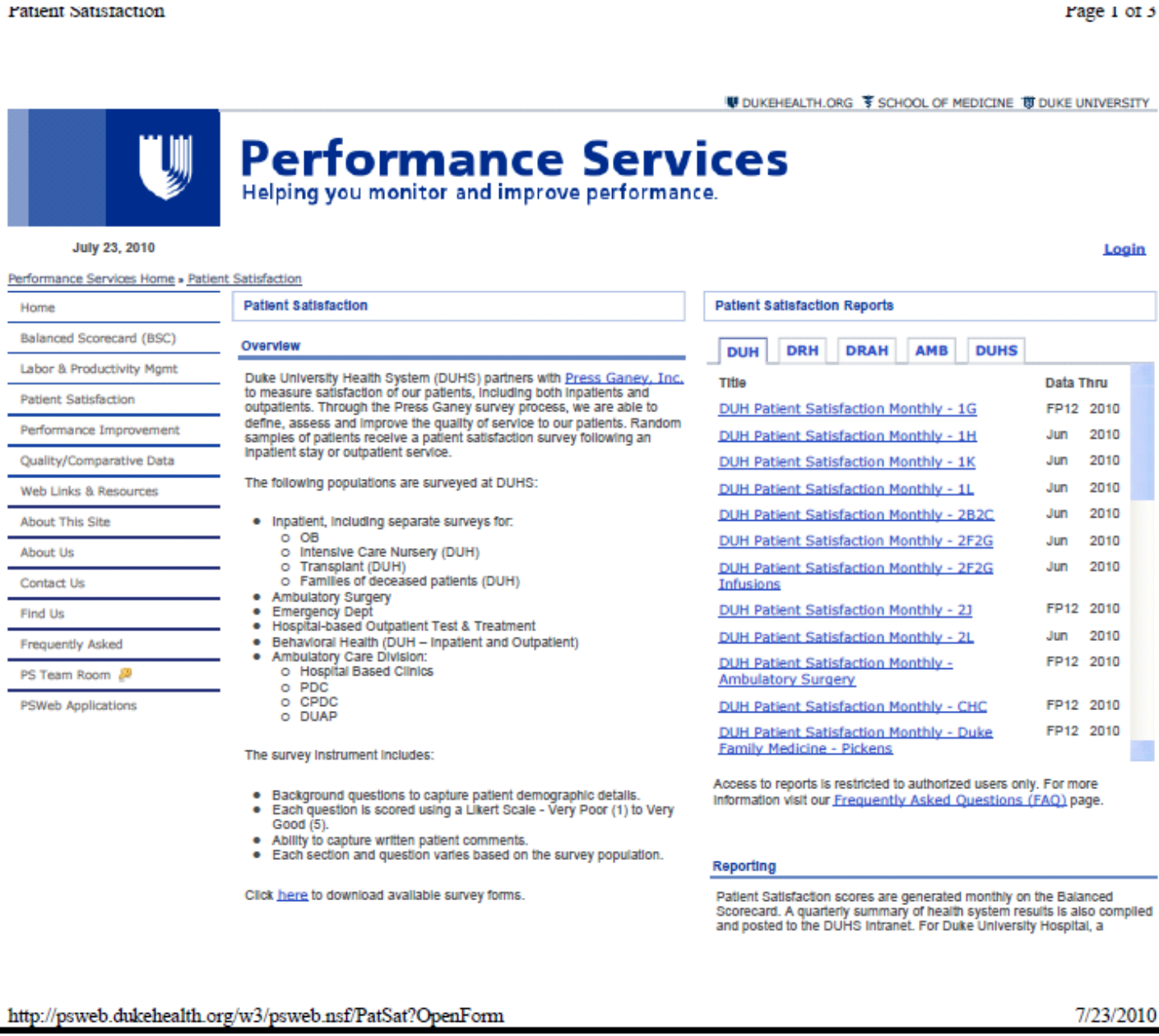
Mini-Clinical Evaluation Exercise (CEX)

Evaluator:_____ Date:_____

1. What did you observe the resident do well?

2. What, if any, errors or deficiencies did the resident commit?

PLEASE COMPLETE MINI-CEX RATING FORM



Patient Satisfaction Page 1 of 5

DUKEHEALTH.ORG SCHOOL OF MEDICINE DUKE UNIVERSITY

Performance Services

Helping you monitor and improve performance.

July 23, 2010

Login

Performance Services Home » Patient Satisfaction

- Home
- Balanced Scorecard (BSC)
- Labor & Productivity Mgmt
- Patient Satisfaction
- Performance Improvement
- Quality/Comparative Data
- Web Links & Resources
- About This Site
- About Us
- Contact Us
- Find Us
- Frequently Asked
- PS Team Room
- PSWeb Applications

Patient Satisfaction

Overview

Duke University Health System (DUHS) partners with Press Ganey, Inc. to measure satisfaction of our patients, including both inpatients and outpatients. Through the Press Ganey survey process, we are able to define, assess and improve the quality of service to our patients. Random samples of patients receive a patient satisfaction survey following an inpatient stay or outpatient service.

The following populations are surveyed at DUHS:

- Inpatient, including separate surveys for:
  - OB
  - Intensive Care Nursery (DUH)
  - Transplant (DUH)
  - Families of deceased patients (DUH)
- Ambulatory Surgery
- Emergency Dept
- Hospital-based Outpatient Test & Treatment
- Behavioral Health (DUH – Inpatient and Outpatient)
- Ambulatory Care Division:
  - Hospital Based Clinics
  - PDC
  - CPDC
  - DUAP

The survey instrument includes:

- Background questions to capture patient demographic details.
- Each question is scored using a Likert Scale - Very Poor (1) to Very Good (5).
- Ability to capture written patient comments.
- Each section and question varies based on the survey population.

Click here to download available survey forms.

Patient Satisfaction Reports

DUH | DRH | DRAH | AMB | DUHS

Title	Data Thru
DUH Patient Satisfaction Monthly - 1G	FP12 2010
DUH Patient Satisfaction Monthly - 1H	Jun 2010
DUH Patient Satisfaction Monthly - 1K	Jun 2010
DUH Patient Satisfaction Monthly - 1L	Jun 2010
DUH Patient Satisfaction Monthly - 2B2C	Jun 2010
DUH Patient Satisfaction Monthly - 2F2G	Jun 2010
DUH Patient Satisfaction Monthly - 2F2G Infusions	Jun 2010
DUH Patient Satisfaction Monthly - 2J	FP12 2010
DUH Patient Satisfaction Monthly - 2L	Jun 2010
DUH Patient Satisfaction Monthly - Ambulatory Surgery	FP12 2010
DUH Patient Satisfaction Monthly - CHC	FP12 2010
DUH Patient Satisfaction Monthly - Duke Family Medicine - Pickens	FP12 2010

Access to reports is restricted to authorized users only. For more information visit our Frequently Asked Questions (FAQ) page.

Reporting

Patient Satisfaction scores are generated monthly on the Balanced Scorecard. A quarterly summary of health system results is also compiled and posted to the DUHS Intranet. For Duke University Hospital, a

http://psweb.dukehealth.org/w3/psweb.nsf/PatSat?OpenForm 7/23/2010

Measuring Patient Satisfaction

DUHS measures patient satisfaction within the Customer Quadrant of the Balanced Scorecard. DUHS measures patient satisfaction based on two critical success factors, Overall Mean Score and the Percent of "Very Good" Responses. These measures are defined as:

- Mean Score: The average of all question scores using the following conversion:

	Very Poor	Poor	Fair	Good	Very Good
Scale=	1	2	3	4	5
Score=	0	25	50	75	100

- Percent of 'Very Good' Responses: Number of times that patients scored us a 5 'Very Good' divided by the count of questions.

Service Improvement

The Duke University Health System and Medical Center demonstrates a clear commitment to provide the best in service to our patients, families and staff.

Through our Service Improvement efforts we try to continuously improve all aspects of the Duke experience for both external and internal customers by positively impacting our service delivery systems:

- Our Processes
- Our Employees
- Our Environment

This work is conducted through a variety of ways on individual units as well as through house-wide efforts.

For more information about Duke's Service Improvement program please check out: serviceimprovement.dukehealth.org
or contact Tonya Miltier (919.668.9063).

Project Impact

Real Time Survey
This process provides a method to continuously measure patient satisfaction on a real time basis. The Real Time Survey allows us to receive immediate feedback from our patients and families and provides an opportunity for on the spot service recovery prior to the patient's discharge.

Strive For Five

quarterly trend for overall mean score, percentile rank and percent very good as well as the Executive Summaries for each patient population are emailed to Senior Leadership, HLC, PIOC, CSU Executive Leadership, Patient Safety and Clinical Quality, Department Heads, and Nurse Manager groups. All of the latest reports for all entities are accessible in the above content window.

Online Query Tool: eCompass

Press Ganey's eCompass is an Internet-based reporting tool for Patient Satisfaction.

- This web tool provides:
  - Detailed performance ratings & demographics
  - Respondents comments
  - Solutions for performance improvement
- Password-protected system safeguards PHI and potentially sensitive performance data.
- If you have a login to eCompass, you can access it via www.pressganey.com.
- If you would like to request access to eCompass, please contact the account administrator within Performance Services at 919.668.9098 or email Pam Turner.

Patient Satisfaction University

A training program developed to educate staff about Patient Satisfaction and the available tools and resources. To participate or find out more details about this program, please email Pam Turner or Tonya Miltier.

Download and review the entire training presentation below:

Patient Satisfaction University.ppt

This campaign focuses on education and communication on the Press Ganey survey instrument to achieve the highest level of performance and move the 4's to 5's.

For more information contact Pam Turner (919.668.9069) or Tonya Miltier (919.668.9063).

Chapter 6: VA-Specific Information

In this chapter you will find guidelines that are specific to the Durham VA Hospital. These guidelines are subject to change, so please be sure you are using the current guidelines.

NOTE: This chapter pertains only to the Durham VA Medical Center. Guidelines for other facilities (Durham Regional Hospital and Duke Hospital) can be found in other chapters of this orientation package.

Orientation:

If your salary is paid in part by the VA, Human Resources (286-0411 x 6901, located at 411 West Chapel Hill St.) will schedule you for a mandatory orientation session to complete your required paperwork, benefits, etc. You will need to be fingerprinted.

To get parking: The VA provides 2 options for parking. One garage provides free parking. This garage is 5 blocks down Erwin Avenue (free, shuttle available). Take the signed form provided by Human Resources to the VA police office located on the first floor, A1013. The other garage is adjacent to the hospital. You will have to pay approximately $32/month. Please go the Building 6 for more information.

To get your ID badge:

The VA ID badge is a federally-mandated PIV identification card. The process for obtaining your PIV card will take several days involving multiple steps. Your section administrator must enter information about you into the system for a background check, then you must be fingerprinted in the PIV office near the VA library (ground level). You will need to return several days later for the final process and issuing of the card. Allow 30-45 minutes for each appointment.

Credentialing:

The Medical Service Office (C8017, 286-6941) will contact you to provide the appropriate paperwork, which is similar to Duke's process.

Training:

The VA has a number of required online training modules that must be completed annually. Check with your service's Administrative Officer or Director to see what modules you need to complete, or contact the education office at 286-0411 x 6909.

CITI (ethics modules for IRB credentialing): https://www.citiprogram.org/default.asp?language=english

VA Talent Management System:
https://www.tms.va.gov/plateau/user/login.jsp

Computers and Communications

Computer training/passwords:

In order to gain access to VA computer systems, users must contact the ADPAC for the service they are working for:
-For Medical Service – Karen Higgins at ext. 5798 or email Karen.higgins2@va.gov,
-For GRECC/Extended Care – Thomas Simmons at ext. 6772 or email Thomas.simmons@va.gov
-For Ambulatory Care Carla Hyman at ext. 4622 or email Carla.Hyman@va.gov

ADPAC's can also assist with getting citrix access. If you do not sign on to the system for 90 days, your account will automatically be disabled. You can contact the ADPAC for assistance in reactivating. If it is during non-duty hours such as holidays, nights, or weekends, you should contact the VA Helpdesk at ext. 5812 for assistance. In order to gain initial access, reactivate an account, or maintain your account, all users must be up-to-date on the following annual mandatory training requirements:

1. VHA CO Compliance and Business Integrity (CBI) Awareness Training
2. VA Privacy and Information Security Awareness and Rules of Behavior
3. Privacy and HIPAA Training

Accounts cannot be activated or re-activated if any of these are missing or out of date and computer accounts will be suspended if allowed to expire.

CPRS training is generally provided by one of the Clinical Applications Coordinators – usually Sonny Roaquin. This training should be scheduled in advance and is generally 2 hours long. You can contact your section secretary for assistance with scheduling.

Computer security:

The VA is very strict about computer security. Do NOT plug ANYTHING into a VA computer (e.g. thumb drive, Ipod, Iphone, anything with a USB connection). Similarly, any laptops that are used to store VA data must be approved by IRM.

Email:

The VA uses Microsoft Outlook system, but you cannot automatically forward messages to your Duke address. Once you are enrolled in the system, Karen Higgins will let you know your VA email address (typically, firstname.lastname@va.gov unless someone in the VA has the same name, in which case there will also be a number). Just like you will check your Duke mail on a regular basis, you should check your VA mail. The medicine office will send you mail to both your VA and Duke addresses, but others at the VA will not routinely use your Duke address.!

Phone system:

- **The main hospital number** is (919) 286-0411. All phones have an additional 4 digit extension; inside the VA you only need to dial the extension.

- **To dial OUT** from a VA phone or fax machine to a local number, dial 99 and wait for the dial tone. For local and long distance calls, dial 99, then 1, then area code and number.

- **Directory:** VA operators are available at 286-0411 (or "0" inside the VA), but are notorious for misdirecting calls. To access the facility phone directory on a VA computer: double click the VISTA icon, enter your username and password,", type "phone", enter the name or office you are trying to locate. There is also a telephone icon on the desktop of VA computers which contains several listings of pertinent telephone numbers and locations.

Research at the VA:

Call or visit the Research Office, A2011 with any questions, 286-0411 x 6926.

IRB protocols:

Forms are available from the IRB office, or electronically on the shared S: drive of the VA computer in the "Research forms" folder. New protocol submissions must be received by the 3rd Monday of the month to be eligible for review the following month.

VA Funding:

Information and Requests for Proposals (RFPs) are available at http://www.research.va.gov/. Note that if you intend to submit a grant you need Durham VA Research Office approval, so contact them early if you are considering submission.

General information

Timecards, requesting leave, etc.:

Your Administrative Officer should explain the timecard process for your area, and enter your "tour of duty" hours into the computer system. You must enter leave requests in VISTA (on a VA computer: double click the VISTA icon, enter your username and password, get to the "employee menu" if you are not already there by typing "employee", type "leave request" and follow the instructions). After entering the information, enter 'S' to save request and then enter 'E' to exit.

Travel:

If you are traveling on VA business, have your service administrative staff initiate the paperwork well ahead of time, and be prepared to follow up with phone calls and emails

to check on things. Most reservations must be made by the travel office (919) 286-0411 x 6237. If it is your first time traveling, there is a vendor form that must be completed to enter you into the VA system. This is in addition to your travel request paperwork.

Uniform shop/laundry:
Contact medicine service (x6941) to get form/approval for white coats. Then you can take the form to the laundry room, NG008, 286-0411 x 5260, to get the coats. You can also take coats to the laundry room to have them cleaned.

Attending Responsibilities
VA Medical Service

In this section you will find guidelines for attending at the VA. However, these guidelines change fairly often. Please be sure you are using the current guidelines.

NOTE: This chapter pertains only to the Durham VA Hospital. Guidelines for attending at Duke Hospital and Durham Regional Hospital can be found in other chapters of this orientation package.

Initial Evaluation:

Initial evaluation must be on all charts within 24 hours of the recorded admission time.

- As soon as you can get to a VA computer in the morning, please start a Medicine- Attending Admission note and save it without signing. You can complete it later after you have seen the patient, but the date and time you first saved it will be the time of record.

- All patients who are admitted to your service (observation status, full admit, transfer out of ICU, transfer from other services such as surgery, osh transfer) need to have a Medicine- Attending Admission note. If a patient is admitted to your service, but then is reassigned to a different team in the AM (e.g. bounce back to another team), the attending on the other team accepting the patient will staff that admission.

Follow-up Notes:

Each patient must have an attending follow-up note a minimum of every 3 days. However, we recommend that at least every other day you provide a) a written addendum to the resident/intern daily progress note (a signature without writing something in an addendum does not “count”), or b) a separate Medicine-Attending Follow-up note.

Attending supervision of residents:

- In the initial Medicine Attending Admission note you must indicate in writing that you have read and discussed the team’s Plan and Assessment and that you either agree or disagree with them (this note includes a template paragraph for documenting this). If you disagree, indicate the areas of disagreement.

- Please try to read the new patient H&Ps before rounds so that you are familiar with the new patients. This will help you to speed things up if the presenter gets bogged down, allowing you time to 'run the list' on all old patients each day.

- In your follow-up notes you must indicate that you have discussed or read the current assessment and treatment of the patient and that you either agree or disagree with them. If you use the Medicine-Attending Follow-up note, this includes a template paragraph for documenting agreement/disagreement. If you addend a resident/intern note, you need to type this in yourself. If you disagree, indicate the areas of disagreement.

- If a patient's management has been discussed with you, the house staff should indicate in their daily progress note that the patient has been discussed with you. If they do not discuss a patient with you, their daily progress note should indicate only that you are the Attending for the patient.

Quality of House staff notes:

- The initial plan for each patient should identify all drugs administered and the reason for their use.

- All follow-up notes should indicate any new drugs or changes in dosages and the reasons.

- All daily progress notes should indicate the status of all new and major problems and an evaluation of whether the current therapy is working, and if not plans to change it.

    - An important subset of this is that any patient who has a pain score >0 should have it addressed until resolved or the patient indicates and the house staff records that the patient is satisfied with their current pain management.

- With the EXCEPTION of the resident or intern's initial H&P, nothing should be copied from a note by another author. In the case of the H&P the author of the note must be identified.

- You must develop your policy on whether or not you want your house staff to copy and paste laboratory and other data. If you do allow it, you should require that an assessment of all new, significant and/or changing data should be included in the resident/intern note.

  You are legally responsible for all procedures performed on your patients. You should indicate to the house staff what and what does not need to be discussed before and after performing procedures.

- The discharge summary should be completed by the resident within 3 days of discharge unless there are compelling reasons to allow a longer time. You will get an alert in CPRS that there is discharge summary available for co-signature.

Please read and sign all discharge summaries that HAVE BEEN SIGNED BY THE RESIDENT and indicate that a co-signature is needed. If the alert says "UNSIG/UNCOS'D", do not sign this note because it means the resident has not finished the note.

Rounds:

- On Monday-Thursday, teams generally begin rounds with the attending between 8:00 and 8:30 am, and must be done by 10:45 am. Resident report begins promptly at 11am. On Friday, attending rounds usually start after ground rounds at about 9:15 am and there is no resident report. The time that weekend rounds start should be determined by the attending.

- Both teams admit daily on weekdays. On weekends, the intern only team takes night float handoff patients and the resident only team takes new admissions. Plan to have new patients every day and plan to round in person every day. A schedule detailing you team assignment will be sent to you prior to your time as attending.

Quality Assurance

The VA has national and local “Performance Measures/Indicators” that are tracked and reported. These indicators assist us in ensuring patients are receiving safe high quality care. A few of these indicators include Clinical Reminders, Resident Supervision, Encounter-Billing report, and monitoring of compliance with mandated documentation expectations such as timely “Admission” and “DNR” documentation.

- Clinical reminders are used nationwide, and we are compared to other facilities in meeting standards. They consists of functionality within the computerized medical record (CPRS) that periodically reminds clinicians when a patient is due for a specific clinical activity, such as a flu shot, diabetes maintenance, or Colorectal CA screening. Clinical Reminders are triggered by information that has been entered into the patient’s medical record at some time in the past.

- Recent emphasis for clinical reminders has been on LDL cholesterol control in patients with a history of myocardial infarction (i.e., does not need to be their admitting diagnosis), diabetes, peripheral vascular disease, cerebrovascular disease.

- Your housestaff have been charged with completing clinical reminders, and we will provide them with weekly reports. Clinical Reminders are reported monthly to the Medical Specialty service areas. The service should review the report for compliance in completing reminders and share the results with the group.

- We will also retain information on how well you, as the attending physician, supervised your housestaff in the completion of the reminders if you have a clinic

built with your name attached. For all other clinic types the information will be service specific.

- Encounter-Billing reports are reported annually for Attendings that rounded anytime during a month. This report is geared to ensure you are coding properly and completing encounters. A dollar figure is attached per the codes to show what the VA could charge, and does to 3rd party insurers, if they were an institution like Duke.

VA General Medical Service Curriculum

Education Goals:

The VA General Medicine Service provides the opportunity to develop the diagnostic and management skills central to inpatient general internal medicine. Providing safe, effective, and compassionate care to our patients remains our top priority. In addition, residents will continue to develop their skills in the critical appraisal of the medical literature in order to guide medical decisions with the best evidence available. Interns and especially residents will also have the opportunity to improve their skills as teachers through their close work with medical students.

Educational Content:

The VA General Medicine Service provides exposure to the entire range of acute conditions that comprise inpatient internal medicine, including conditions specific to all subspecialties. From the local area we serve, we receive a significant number of patients who present acutely to our clinics and emergency department. We also act as a tertiary referral center within the VA system, which broadens the experience and degree of exposure within internal medicine. These patients require a diverse array of procedures that the residents and interns perform (with supervision when appropriate).

Lines of Responsibility:

Each attending has two teams. A typical team includes one to two students, an intern, and a junior assistant resident. Some attendings will work with the two SAR-Ex teams which consist of a senior resident and possibly a sub-intern. Some SARs will also provide day float coverage.

- The resident serves as the leader by supervising other team members, taking responsibility for patient management, and taking an active role in the education of the intern and students.

- The intern or sub-intern should act as the primary physician for the team's patients and orchestrate the daily ward management of the patients. The intern will follow all patients assigned to second year medical students and PA students. Sub-interns report directly to the resident, and the intern will not be involved in the day to day management of the sub-intern's patients.

- Two teams will share a General Medicine attending, who is ultimately responsible for the patients. **All invasive procedures (cardiac catheterization, surgery, and radiologic procedures) must be discussed with the attending prior to the procedure.** The resident should clarify the definition of "invasive procedure" with each attending at the start of each rotation.

Reading Lists:
The Duke tradition of teaching has always taken a patient-centered approach. Rather than providing a core reading list specific to this rotation, we expect residents to use each patient as the basis for an investigation into particular aspects of internal medicine.

Principle Teaching Methods:
The ultimate educational goal is to provide residents and interns with the skills that promote and facilitate independent, life-long learning. One area of emphasis will be in the practice and teaching of evidence-based medicine. We encourage YOU to obtain and read the book "Teaching in the Hospital" by Wiese.

Sign-out rounds: The chief resident and the assistant chief resident return to review the patients who the night float teams have admitted. During sign-out rounds, which typically occur from 9pm until midnight, we discuss various aspects of the case, taking advantage of educational tools available on-line via the Duke Medical Library website. Through both online and textual resources, we are able to immediately access pertinent journal articles and other resources to answer clinical questions and also to direct the resident's reading. We encourage the review of radiographs, gram stains, blood smears, urine sediments, etc.

Morning Report:

- **Residents**: Every Monday through Thursday, residents meet from 11 am to Noon to discuss interesting cases. Different members of the faculty join us and serve as the discussant. One of the residents prepares a case presentation as well as a critically appraised topic (CAT). The CAT is an in depth discussion of an article. The article is chosen by the resident based on a clinical question that stems from the case.

- **Interns:** Intern morning report is held every Tuesday at 1:30pm. Different members of the faculty join us and serve as the discussant. One intern presents a case and then leads the group in discussion of the disease. Radiographs and other data should be brought to report. When appropriate, the microscope and accompanying monitor can be used to illustrate the interpretation of tissue biopsies, blood smears, and bone marrows. The chief resident and assistant chief resident are available to help the intern in preparation for intern report.

Chair Conference:
Every Friday at noon, the residents, interns, and students join the Duke General Medicine teams for conference with the Chair of Medicine or his designee. A resident presents a case as an unknown, and the discussant will lead the group through the work-up and management of that patient.

Attending Rounds:
On all days of the week, the residents, interns, and students meet with their attendings for teaching rounds. New patients are presented to the attending and old patients are quickly reviewed. Our preference is for bedside teaching rounds on new patients, but the final location for each presentation is left to the attending and the team. Each student is responsible for presenting one of his or her cases from the previous day. The intern presents all other cases that (s)he evaluated. The resident presents further cases including the handoffs from the night float teams. These rounds should ~~last~~ start between 8:00 and 8:30am and end no later than 10:45 on Monday – Thursday. On Fridays, rounds start typically at about 9:15 (after Department of Medicine grand rounds) and there is no resident report at 11AM. You should expect to round in person on the weekends to staff the new patients. The start time for weekend rounds should be determined by the attending.

> You should expect round in person and hear about new patients to be presented to your team on Saturday or Sunday.

Noon conferences:
Conferences are held Monday through Thursday at noon. On a rotating basis, the conferences include Journal Club, Morbidity and Mortality, Ambulatory Care Conference, Gallops (interesting imaging/physical findings/pathology), EKG conference, State of the Art lectures by faculty, SAR talks (lectures given by each senior resident), medical jeopardy, and the Women's Health Series.

The Department of Medicine web site at http://medicine.duke.edu/ maintains an updated copy of the conference schedule at the Calendar tab. Residents and interns on VA general medicine rotation are expected to attend all conferences unless an urgent patient care issue prevents them from doing so.

Grand Rounds:
Each Friday at 8:00 am, a member of the faculty or a distinguished visitor makes a presentation to the department detailing original research or highlighting a relevant topic in internal medicine.

Evaluation Methods:
Residents and interns will be assessed by the attending for their overall clinical competence, humanistic qualities, and potential for academic medicine. Specific categories of assessment include history taking, physical exam skills, ability to evolve a reasonable plan of patient management, medical knowledge, collateral reading (residents only), judgment, intellectual honesty, and maturity. At the end of the rotation,

(and hopefully midway through as well if you have the same group for 2 weeks), the attending physician meets individually with each resident, ~~and~~ intern, and medical student to provide feedback. At the end of the rotation, the attending will be sent a link to complete an electronic evaluation for each resident and intern. The evaluations can then be reviewed by the intern or resident. Also, the attending is sent a link to complete an electronic evaluation for each medical student. The residents and interns can complete evaluations of the attending, and these are sent in aggregate to the attending for review.

Admitting schedule:

General Structure:

During the 4 week block, teams will have 3 weeks of day coverage and 1 week of night coverage. Interns and JARs will rotate together throughout the block.

General Teams:

There will be a total of 8 admitting teams, Red 1-3, Blue 1-3, and Red 4 (SAR/Ex), Blue 4 (SAR/Ex). Teams 1-3 will be composed of a JAR and Intern and will take daily admissions as described below with every third day being a "late" day to bridge until the night team arrives. The SAR/Ex team will be composed of a SAR (and possibly also a sub-I with the long term goal of having a physician extender). This team will also admit daily except only 1 handoff on one weekend day per team.

Week 1			Week 2			Week 3			Week 4		
TEAM	**INTERN***	**JAR**	**TEAM**	**INTERN**	**JAR**	**TEAM**	**INTERN**	**JAR**	**TEAM**	**INTERN**	**JAR**
Red 1	**A**	**A**	Red 1	**A**	**A**	Red 1	**A**	**A**	Red 1	**B**	**B**
Red 2	**B**	**B**	Red 2	**B**	**B**	Red 2	**C**	**C**	Red 2	**C**	**C**
Red 3	**C**	**C**	Red 3	**D**	**D**	Red 3	**D**	**D**	Red 3	**D**	**D**
Red NF	**D**	**D**	Red NF	**C**	**C**	Red NF	**B**	**B**	Red NF	**A**	**A**
Blue 1	**E**	**E**	Blue 1	**E**	**E**	Blue 1	**E**	**E**	Blue 1	**F**	**F**
Blue 2	**F**	**F**	Blue 2	**F**	**F**	Blue 2	**G**	**G**	Blue 2	**G**	**G**
Blue 3	**G**	**G**	Blue 3	**H**	**H**	Blue 3	**H**	**H**	Blue 3	**H**	**H**
Blue NF	**H**	**H**	Blue NF	**G**	**G**	Blue NF	**F**	**F**	Blue NF	**E**	**E**

*interns carrying over from last block

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1 1 Late 2 Regular 3 Regular	2 1 Regular 2 Late 3 Regular	3 1 Regular 2 Regular 3 Late	4 1 Late 2 Regular 3 Regular	5 1 Regular 2 Late 3 Regular	6 Red Int/Blue Res OFF, Only Red Admits 1 Regular 2 Regular 3 Late	7 Red Res/Blue Int OFF, Only Blue Admits 1 Late 2 Regular 3 Regular
8 1 Regular 2 Late 3 Regular	9 1 Regular 2 Regular 3 Late	10 1 Late 2 Regular 3 Regular	11 1 Regular 2 Late 3 Regular	12 1 Regular 2 Regular 3 Late	13 Red Res/Blue Int OFF, Only Blue Admits 1 Late 2 Regular 3 Regular	14 Red Int/Blue Res OFF, Only Red Admits 1 Regular 2 Late 3 Regular
15 1 Regular 2 Regular 3 Late	16 1 Late 2 Regular 3 Regular	17 1 Regular 2 Late 3 Regular	18 1 Regular 2 Regular 3 Late	19 1 Late 2 Regular 3 Regular	20 Red Int/Blue Res OFF, Only Red Admits 1 Regular 2 Late 3 Regular	21 Red Res/Blue Int OFF, Only Blue Admits 1 Regular 2 Regular 3 Late
22 1 Late 2 Regular 3 Regular	23 1 Regular 2 Late 3 Regular	24 1 Regular 2 Regular 3 Late	25 1 Late 2 Regular 3 Regular	26 1 Regular 2 Late 3 Regular	27 Red Res/Blue Int OFF, Only Blue Admits 1 Regular 2 Regular 3 Late	28 Red Int/Blue Res OFF, Only Red Admits 1 Late 2 Regular 3 Regular

Admissions:

Mon-Fri: An admission team order list will be created each evening based largely on team census. First, the four "regular call" teams will be ordered 1-4 based on increasing census to receive the first 4 admissions. Next, the two "late call teams" for the following day will be up to receive the next two overnight admissions. Lastly, the next two go to the SAR/Ex teams with the goal being to have the SAR teams open to admissions during the day. However, the order can vary based on census. After the overnight teams' shift is done, the teams are re-organized as below to both maintain the general admitting order and also maximize potential for late admission.

- All JAR/Intern teams can accept the same number of admissions per weekday, but the late teams are designed to be able to accept them later in the day.
- The "regular call" teams can accept up to 2 daytime admissions + 1 overnight handoff or 4:30pm, whichever comes first.
- "Late call" teams can accept up to 2 daytime admissions + 1 overnight handoff or 6:30pm, whichever comes first.

- If a team does not receive an overnight handoff, that team can still only receive up to 2 daytime admissions.
- If a team receives two overnight handoffs, they can only admit 1 patient during the day. As previously, bounce-backs do not count against daily admissions.
- On the weekends, the regular team accepts admissions until 4:30pm and the late team accepts admissions until 6:00pm.
- "SAR/Ex" teams can accept 2 handoffs or 1 handoff + 1 daytime admission or two daytime admissions before 4:30pm.

The late call resident (Red Resident – odd days, Blue Resident – even days) should sign on to the admissions pager (970-0546) in the morning. At 3:30-4PM, the late call resident is to contact Carol Howard/Bed Control at pgr 970-2742 or receive list in Surgery Conference room on 5th Floor. After 3:30 on long call days and on the weekends, that resident is responsible for giving team assignments.

Fri and VA holidays: On Fridays and VA holidays, the structure will be similar to Mon-Thur except that regular call teams will stop admitting at 4:30pm and late call teams will stop admitting at 6:00pm. Overnight residents are asked to come in at 6:30pm on Friday-Sunday and VA Holidays. SAR/Ex service is unchanged on Fridays.

Sat, Sun: On the weekend, there will be one day when all blue residents are off and red residents work, and the other day will be the opposite for coverage. Interns will be off on weekend days that residents are working. There is little flexibility in this system. Sister team residents are available for intern supervision. Also, the SAR resident is to check on the interns periodically during the day and be available for assistance with procedures, questions, etc.

When the team's resident is off, those teams will not receive daytime admissions but can accept up to 2 overflows which will preferentially be given to the intern only teams that morning. On weekend days when the intern is off, the regular call team resident can accept up to 2 admissions until 4:30pm (2 regular call teams each weekend day). Handoffs are included in this number on weekends but are directed to intern-only teams first as mentioned above. The late call team can accept up to 3 admissions (handoff or daytime) until 6:00pm (see template below). Late call is listed first in this template in attempt to give that team the first opportunity at an overnight handoff if available and to try to avoid getting two patients in a row late in the afternoon for the solo resident. It is anticipated that the late call resident on the weekend will likely be the most demanding shift of this structure.

Again, night teams will be asked to come in at 6:30pm on Friday-Sunday and VA Holidays.

SAR/Ex service can accept only one new handoff admission on weekends for the resident who is on that day after the interns have accepted their capacity. SAR/Ex does not accept new daytime admissions on weekends, unless the teams cap early and approved by the ACR/CMR.

Overnight Teams:

- The overnight intern/JAR teams (and also the 2 "SAR only" teams on Sunday nights) can accept up to 5 patients on each of the two teams until 6:00am.
- These patients will be assigned to teams overnight by one of the two residents according to census using the templates above and distributed among the teams in the morning with the direct sign-out from the overnight team to the accepting resident.
- Overnight, the 970-0546 pager will receive notifications of admissions from the Off-Tour-Coordinator (OTC) or MOD, and the resident will assign the admissions upon receiving the page to the next team in order on the list.
- On weekends, that resident will be responsible for giving team assignments as above. The 970-0546 pager will also serve as a backup pager for overnight nurses if they are having difficulty reaching the appropriate resident.
- Interns are responsible for overnight cross cover and sign out cross cover events to the respective interns or SARs in the morning.
- **Both intern and JAR should be out of the hospital no later than 8am.**
- When the team that was on nights transitions back to days, they will take over the team that is coming on to nights. Yes, this does mean they won't get their old team back; however, it's pretty unlikely that too many of the patients will still be on service one week later. Also, they'll be admitting to all teams of the same color (red or blue) and covering all teams overnight so they will get to know the patients they will be taking over.
- As for the transition, if the patient has been hospitalized for ≥4 days or is particularly complex, an interim discharge summary should be done by the offgoing resident. If a patient gets discharged on the first day a new resident is on service, the previous resident is responsible for the d/c summary.

Admissions:

A generally come from four locations: the ER, outpatient clinics, an outside hospital, or the ICU. ER and outside hospital transfers are coordinated through the AOD, who locates the bed space and makes the team assignments. If the accepting resident is concerned about the appropriateness of an admission, (s) he should discuss the case with the assistant chief resident.

ICU Transfers:

When a patient that is assigned to a General Medicine team is transferred to the ICU and is then ready to return to that team, the patient is **transferred back to the original team**. This does not count as an official admission to that team. The patient being transferred goes back to the original team as long as either the resident or the intern took care of the patient prior to the ICU stay. It is very rare that we will accept a medicine patient boarding in the ICU, and the chief resident should be involved in any case where that is being considered.

Days Off:
The Department of Medicine has a schedule that gives every resident and intern an average of at least one day off a week. At least one member of the team rounds on the service each day. Students on VA general medicine get two days off per month. Student days off will be at the discretion of the resident.

Absences:
Occasional circumstances necessitate absences and therefore require coverage for a clinical service. However, all absences from any clinical service require the approval of the Chief Resident in advance. Arranging coverage with other residents without notifying the CR is unacceptable.

The Medical Record:
This is an essential form of communication between the team and consultants, cross-covering interns, and the attending physician.

- **REMEMBER**: All information not mentioned is assumed to be normal in electronic medical records. Only state the most pertinent negatives and normal findings. Also, refer back to work that has previously been done rather that repeating the typing.

- **The resident should fill out or edit the computerized problem list.**

- Residents, interns, and sub-interns must enter their entire note as a computerized progress note for all admissions and transfers. **Interns should complete their note in the "Medicine Admission H&P" template. Residents should use this template if they are admitting a patient by themselves.** Only residents are required to write a computerized transfer note for a patient from the MICU/CCU.

- Intern admission notes must address all relevant areas in the history and physical including pain assessment and functional status.

- The resident admission note should also document if the admission is related to a **service-connected condition** and the **anticipated length of stay**.

- Even if incomplete, the resident should prepare and sign their notes in the computer before 6 a.m. to facilitate review by the attending. If incomplete notes are signed, then the original should state that it is incomplete and the resident adds further information in an addendum.

- We expect resident plans to be referenced to the supporting literature. This can be added as an addendum after the original note is signed.

- Progress notes should be daily, brief, and should cover any diagnostic/therapeutic activity or any change in the patient's status. They

must be entered in the computer. They should also include the anticipated length of stay (on a daily basis) and highlight any discharge planning issues.

Every patient must have an MD note every day except for day of discharge- a student note (including a sub-intern note) does not suffice. The resident or intern needs to do a separate note or make an addendum containing all the elements of a daily/SOAP note that is then added to a student note. A resident cannot addend a student note with an addendum that only states that they agree with the above note.

- Second year students should prepare their own admission database. They should use the template called "Medicine – Student Admission Note". Remember that the preliminary Word document needs to be saved on a floppy disk and not on the desktop. A 2nd year student's admission database cannot replace the intern's as the official chart copy.

- All student admission and progress notes must be co-signed by the resident or intern. This is a JCAHO requirement. Student notes cannot be seen without the co-signature.

- **Interns need to write pending discharge orders and discharge patients as early as possible on the day of discharge.**

VA Survival Tips and Helpful Hints

Medicine Floor Setup:

Most medicine patients are located on the 6th and 7th floors: 7B (telemetry unit), 7A, 6A, and 6B. Occasionally post-procedure observation patients are on 4B.

Days Off:

As stated in the formal section, every resident and intern will have one day off per week averaged over a four-week time period. The resident and intern have assigned days off each weekend.

Hospitalist Team:

This service will be comprised of two teams, Bluehosp and Redhosp. These teams will be staffed by mid-levels, NP and PAs, and supervised by the hospitalist attending. The goal of the hospitalist service is to reduce resident and intern patient census, increase inpatient capacity, and improve resident learning opportunities. The hospitalist service will accept low complexity patients as transfers from the inpatient teams. Possible patients include those admitted for routine chemotherapy or hemodialysis initiation or those with difficult disposition status but medically stable. To transfer a patient to the hospitalist teams, please contact the appropriate functional pager (blue teams contact blue hosp pager 970-7043 and red teams the red hosp pager 970-7045) to discuss the patient and transfer. If the patient is accepted by the hospitalist attending, then resident does verbal signout if length of stay (LOS) is <=24 hours, otherwise an interim discharge summary should be done. Once the patient is on the hospitalist service, the hospitalist team will be responsible for all orders, medications, consults, procedures, documentation, discharge planning, and patient care. Should the patient's clinical status necessitate care beyond the scope of this service, then transfer back to the general medicine teams will be discussed. If during normal hours, this will be initiated by the hospitalist team attending and the on call team and ACR/CR. At that time, a medicine consult or transfer will be completed. Hospitalist patients are cross-covered by the teaching teams on call.

CPRS:

CPRS is the computer program that all VAs in the country use for notes, orders, consults, lab results, imaging and pathology reports.

All admission, daily progress, nursing, procedure, transfer, and discharge notes are found under the "Notes" section. Discharge summaries have their own section in CPRS. The CPRS training program will teach you how to create, edit, and sign these notes.

All inpatient and outpatient orders can be accessed and added under the "Orders" section. Again, the CPRS training program will teach you how to enter these, but several tips will help interns survive the day-to-day problems encountered with this system. First, be sure about your medication doses and schedules when entering pharmacy orders. Second, be cognizant of your fluid orders as you can limit the total

amount of volume you order by typing in an amount in the “Additional Comments” box. Otherwise, the patient will receive the rate of fluid indefinitely. Third, there are three types of phlebotomy collection choices- “send patient to lab”, “ward collect”/housestaff collect, and “lab collect”. Be sure to order the correct collection or the blood will not be drawn or run. Fourth, it is possible to have all labs ordered by one person sent back to that person with flags. Ask CPRS administrator or current housestaff about this if interested. Finally, if unsure of orders or process, ask your resident or call CPRS Help Desk pager (970-3432) with questions. **NOTE: There are no verbal orders at the VA.**

When ordering Radiology imaging, it is important to call the appropriate Radiology team to alert them of the orders. For example, if you need a CT or MRI- call the appropriate scheduling person and tell them that you have ordered a study and ask them when it might be done. This is likely not necessary for plain films that are ordered for a time in the future (e.g. CXR in am), but should you need an urgent or stat X-ray- call Radiology and tell them about this.

EKG images can be seen using VISTA Imaging. To access VISTA Imaging, while in cprs select tools and pick the "Imaging (ViA Imaging Display)” option- Radiology can be accessed in two ways- the preferred method is via the PACS system which is a program opened from CPRS under the tools bar, option "Imaging Philips (PACS)". It should have all films from the DVAMC and other VAs uploaded. If this is down, you can use VISTA Imaging for plain films.

IV Team:

The IV team places all peripheral lines and PIC(C) lines on the floors. Commonly, the IV team is unable to place peripheral IVs in patients due to poor upper extremity access. Remember that the IV team is only able to place IVs in the arms. Prior to placing central catheters, inspect the feet (nondiabetic/nonmobile patients), brachiocephalic, and external jugular veins as possible alternate sites.

Codes:

There are several different codes to get into different rooms at the VA. For the most part, the code is 1&5 together then 3 except for the entrance into the supply rooms and central computer workroom which is 2&4 together then 3. Ask the current residents for the codes to other rooms. Code for the medical library/conference room is **3-2-1**.

Phlebotomy:

There are four scheduled blood draws Sunday-Friday and three on Saturday. Blood draws are at 6am, 11am 6pm, and 9pm with the exception of Saturdays/holidays blood draws are not done at 9pm. On-call phlebotomy is available during working hours.

Should an intern need to sign out a blood draw either in-between daily blood draws or after hours or on weekends, common courtesy involves ordering the blood (remember to make it “Ward Collect”), picking up the labels and placing them in a phlebotomy bag with the necessary syringes, butterfly needles, appropriate blood tubes, tourniquet,

alcohol wipes, and 2x2 gauze. Labels are printed behind the secretary's desk on each wing. The supplies are kept in the common supply room on each wing.

All blood cultures are drawn by the housestaff at the VA. A similar process as to that described above for sign-out blood draws is necessary for blood cultures. Each tube will need to be labeled appropriately.

NOTE: All blood drawn by housestaff will either need to be taken to the lab by the housestaff/medical student or picked up by transport.

Transfusions:

The transfusion process at the VA is different from that at Duke Hospital. When you decide to transfuse various blood products, you not only have to order the various blood products on CPRS and document a transfusion indication form, but you also have to consent the patient and have him/her sign the form (consent process is now electronic from i-med).

REMEMBER: Type and Screen/Cross cannot be added to blood already in the lab so if appropriate, keep an active Type and Screen on all patients (every 72 hours).

Procedures:

Prior to beginning any procedure, housestaff should consent the patient and prepare the materials necessary to carry out the procedure. Central venous catheters and lumbar punctures are two of the more common procedures done on the sixth floor. Both kits are located in the supply rooms on each wing. However, interns will need to obtain lidocaine, betadine, and sterile flushes in the medication rooms (accessed only with the assistance of a nurse). Please let the floor nurses know if sterile gowns, hats, and masks as well as drapes are not in the MICU or CCU supply rooms.

Due to large patient loads for the nursing staff, the housestaff usually will need to depend on medical students and other team members to assist with positioning and general aid throughout the procedure.

Transportation:

Should you need immediate transport to Radiology for an imaging procedure or blood taken to the lab urgently, you or another team member should consider performing the task yourself. Housestaff are never required to physically transport a patient to an inpatient destination but may choose to do so if the patient condition warrants. Housestaff or staff physicians are no longer required to escort patients from the ED to the ward while on telemetry, this is being taken care of by nursing staff with ACLS training.

Summary of websites in this chapter:

CITI (ethics modules for IRB credentialing): http://www.citiprogram.org/default.asp?language=english

VA Talent Management Service (for required modules): https://www.tms.va.gov/plateau/user/login.jsp

VA Funding: http://www.research.va.gov/

Department of Medicine web site: http://medicine.duke.edu/

Chapter 7: Working at Duke Regional Hospital (DRH)

The DRH Medical Staff Office (470-6253) requests that new attendings contact their office prior to any orientation activities so that they can coordinate and facilitate the process (Donna Huston, Manager). They will assist in vehicle registration, security assignment, ESA initiation (electronic signature), eBrowser/PACS/CPOE training and ID card entry into the hospital and units.

Credentialing:

Medical Staff Services will assist you with credentialing. They need your name, specialty, mailing address, email address, and contact phone number. An application, delineation of privileges and other applicable documentation will be emailed to you. Contact numbers for Medical Staff Services are:

Cindi Murphy, Administrative Assistant – 470-7279
Marvellena Grantham, Credentialing Coordinator – 470-6254
Donna Huston, Manager, Medical Staff Services – 470-6259

Complete the application and supporting documentation and forward to the DUH CVO as indicated in the packet.

Once our application has been approved, you will receive information regarding required online training and orientation at DRH.

PLEASE NOTE: That if you are being credentialed for the first time you should start the process 6 months in advance as it take at least 3-4 months to complete the application review process.

Computers and Communications

Computer access/passwords:

- Cindi Murphy (470-7279) and Marvellena Grantham (470-6254) in Medical Staff Services assist with computer access codes.
- To obtain a Remote Access Account to be able to access DRH computer login from home, contact IS Help Desk at 684-2243 or via web at http://dhts.duke.edu/modules/dhts_home/index.php?id=3 (from DRH intranet only).
- To connect to remote access, use web address: https://vpn.duhs.duke.edu

Communicatons:

- **Paging:** Uses Smart Web Paging System (Dragon Icon) for text paging.
- **Phone system:**
  - **Main Hospital #:** 919-470-4000.
  - Ask for a **pocket Department/Physician phone directory** from Medical Staff Services.
  - **To dial out:** 9 then your number
  - **To dial long distance:** Call hospital operator and ask them to place long distance call for you on hospital related business.

Billing and Coding:

Charges at DRH are currently captured in MDe but will transition to Maestro in the next 6-12 months. For questions related to MDe, please contact the MDe Support Help Desk at 681-5252. Tiny Ellis is the assistant on site for medical coding/billing issues; her office is located in the PRMO office on the ground floor across from the small post office. Her phone number is 470-8487.

Other DRH Information

ID Badge and parking:

Medical Staff Services assists with this when your credentialing application has been approved.

- A separate parking pass is placed on your rear view mirror.
- Your Duke ID is used to enter the Physician's Parking lot and the hospital entrance by this parking lot, but the Duke ID must be activated at DRH by Medical Staff Services.

Medical Records:

Records department referred to as Health Information Management, phone # 470-5172.

The contact person for Dictation and ESA is Beatrice Byrd at 470-8288.

Beatrice will provide a card on how to dictate at DRH (if not received from Medical Staff Services), as well as instructions and password to ESA (similar to eSig at Duke) which is a way to sign your dictations from home, from your Duke office, or while at DRH.

Alternate Contact person is Lisa Hartman at 470-5176.

The MD dictation # is 1-877-629-0808 or if dictating from within DRH you can dial *612.

Orders:

DRH uses CPOE (computerized physician order entry). This system is somewhat different from the Duke Medical Center CPOE.

- Training is available online via the Learning Management System.

Online Note Entry: Progress notes can be generated and signed within NetAccess through direct note entry. In order to do this, providers must complete an online course through the Learning Management System: http://www.hr.duke.edu/training/location/lms/index.php

The name of the course is “Introduction to DRH Provider Progress Notes Documentation”. Once completed, you should notify Kevin Fallon (470-6256) by email for your access to be activated.

Attending responsibilities:

You will often receive an email from the Duke Chief Resident at DRH before your General Medicine Attending rotation. Guidelines for rounding at DRH can be found below. However, this information gets updated frequently, so be sure to refer to the one you get from the Chief Resident before you start your rotation. If you do not receive this letter prior to your rotation, contact the DRH Medicine Chief Resident at 470-6515 or through the DRH operator 470-4000.

On the first day, please take time to go to Medical Staff Services on the second floor to register and obtain parking and computer access information (see above). You may start the process beforehand by calling 470-6254 and speaking to Terri Coburn in Medical Staff Services.

If you have any questions, please call the DRH Chief Resident, at 470-6515 or through the DRH operator at 470-4000.

You may also contact the Site Director Dr Lalit Verma in the Hospitalist Office 470-8490 or email lalit.verma@duke.edu

---

Revised 1/21/11

Rounding Information for General Medicine Attendings at DRH

1. Teams:
   We have four general medicine teams at DRH, each of which includes one senior resident and one intern. Each team usually has a second year medical student and/or PA student and/or a pharmacy student. One gen med attending is assigned to cover 2 gen med teams for two week blocks.

2. Morning Report/Noon Conference
   Morning report is every Monday through Thursday at 7:15 am in Private Dining Room-E on the first floor at the back of the cafeteria. The housestaff on the DRH inpatient rotation and those on the ambulatory rotation attend. Attendings on the teaching service are welcome to attend this conference. The residents will also attend an orientation to the general medicine service the first day of duty; this is held in the same location.

   Noon Conference also occurs in PDR-E Monday-Friday from 12-12:45 PM. We strongly encourage attendings to complete rounds prior to his conference to allow the residents opportunity to attend. Attendings are welcome to attend the conferences which are transmitted from Duke University Hospital.

3. Attending Rounds:
   On days when your teams are short-call and on-call, attending rounds begin at 9:30 and end at 11:30.

   On days when your teams are post-call and pre-call, rounds with the post-call team **should end no later than 10AM**. It depends some on the team dynamic and rounding style, but generally most attendings are finding that it takes 2.5 to 3 hours to complete post-call rounds. This means that the post-call team generally begins rounding between 7:00 and 7:30 AM. The exact hour is flexible with your schedule and personal needs as long as we aim for a 10AM completion. This is to allow ample time for the post-call resident to solidify treatment plans, call consultants, finish notes, and complete adequate hand-off to the team intern and dayfloat and yet leave the hospital before completing a 28 (24 +4) hour shift. There is a **zero tolerance policy for 24+4 hour violations** as is dictated by the local and national GME office. We have found that completing attending rounds much beyond 10:00 or 10:30 a.m. leaves the residents struggling to complete their tasks on time. **Residents must leave the hospital no later then 11 AM on post call days without exception**

   Rounds with the pre-call team generally resume just after the post-call rounds. The pre-call team is encouraged to attend the post-call team rounds, but is expected to attend morning report at 7:15 am Monday through Thursdays, so would join post-call rounds at a later hour. We do recognize that attending rounds are a critical learning

time, so all available parties should attend barring needs to complete critical patient care activities.

When appropriate, we encourage attendings to conduct presentations and teaching at the patient's bedside. Our goal is to teach residents the value of a thorough history and physical exam, and to teach residents how to interact with patients at the bedside.

The resident area is located in the Watts Building on the 3rd floor. The Watts Building is connected to the hospital via the 2nd floor of the hospital, near Radiation Oncology. As you enter the Watts Building (1st floor of Watts = 2nd floor of DRH), the elevators will be on the right. Go to the 3rd floor. Go left out of the elevator, through the door, and take the hallway to the left, then to the right. The Chief Resident's office is on the left. The next door on the left will be the Resident Room. The code is 1-5-1.

The Hospitalist conference room (352) may be used for rounds. It allows for privacy and has a dry erase board.

4. Attending Documentation:
   The Gen Med attending is expected to have an admission note in the chart within 24 hours of admission. This is usually done as an attestation to the H/P dictated by the housestaff in ESA. Please also note that residents CANNOT edit dictations and thus attendings will be responsible for reviewing dictations, and editing for content, errors, and admissions. Please contact lisa.hartman@duke.edu for instructions.

   Daily progress notes are done in NetAccess (until Maestro) and have the ability to insert attestation statements. This can function can also be done offsite via VPN.

5. Radiology:
   If needed, teams may go to radiology and review pertinent films during attending rounds with an available radiologist. You may also view radiology studies on-line via PACS.

6. Call:
   Each team takes long call every 4th night. Team cap is 7 patients on call (5 patients admitted by intern and resident together and 2-3 patients admitted by the resident alone) and total team cap is 14 patients. In accordance with ACGME duty hour recommendations, interns are limited to 16-hour shifts. As such, interns will admit with the resident until 8:30 PM; the resident will then admit 2-3 additional patients between 8:30PM and 3AM. There are hard caps of 14 patients per team, 7 patients per team/24 hours, and 3AM while on long call.

   The hospitalist service admits patients after teams cap and between 3-7AM. We also have short call Monday – Friday (except holidays) up to 2pm or 2-3 patients, whichever comes first. Short call patients will come from a combination of overflow

admissions from the night prior or new admissions that AM. Resident teams can take up to 2 new admissions or 2 over flow admissions + 1 new admission. This is also variable depending on whether the resident or intern has clinic. When one of your teams has long call, the other is on short call. Therefore, *every other day* you will have new patients – on the in-between days, we encourage you to use the extra time in attending rounds to teach on specific topics or ask the students to present on assigned topics.

7. ICU patients:
   The Gen Med teams do not admit patients to the ICU, as this is a closed unit. However, on occasion, patients may be ready for transfer to general medicine but not have a bed available on the regular floor. These patients are placed on floor status in the ICU and will be staffed by the general medicine attending and resident (even if the patient is physically still located in the MICU.)

8. Rapid Response Team (RRT):
   The DRH Hospitalists provide Rapid Response services. Rapid Response Teams have been established nation-wide in efforts to improve patient safety. The RRT can be activated by any member of the patient care team; the RRT will then urgently evaluate the patient and offer suggestions for more intensive management and/or facilitate transfer to the ICU.

9. Day Float Resident:
   Day Float (DF) has been implemented at DRH and the VA in order to help teams comply with RRC duty hours. The DF will round with the post-call teams and assist the post-call resident in leaving the hospital in time as well as to assist the intern with management of the gen med team after the post call resident leaves. There is no dedicated day float on Monday and on those days the DRH/Ambulatory ACR will be available to assist the post call teams (although he/she will also be needed to help coordinate DRH operations including morning report and noon conference). While there will be day floats available from July-Dec, we may not have day floats assigned from Jan-June as the interns will have completed 6 months of training and should be ready to function more autonomously. However, the DRH/Ambulatory will remain available to assist as needed.

10. Housestaff Duty Hours: see discussion under “Attending Rounds” above.

11. Paging system:
    DRH Admissions Resident Pager: 470-1933

12. Billing Information:
    The current billing process for Duke Regional will be MDe until the HER is transitioned to Maestro later this year. Tiny Ellis is the person who assists with any PDC related billing questions; she is located on the ground floor near the post office and dietary office. There are rounding lists in Mde for DRH Gen Med Teams 1&2 and DRH Gen Med Teams 3&4.

13. Consults:
    It is a DRH Medical Staff Policy that residents (not interns) call consults. The policy also requires that the resident speak with their Gen Med attending prior to calling consults, particularly General Surgery consults.

14. On the first day, please take time to go to Medical Staff Services on the second floor to register and obtain parking and computer access information. You may start the process beforehand by calling 470-6253 and speaking to Donna Huston in Medical Staff Services.

If you have any questions, please page DRH Chief Resident.
Thank you so much for your commitment to patient care and teaching!
We truly appreciate your time and effort.

Summary of websites in this chapter

To Obtain Remote Access to be able to access DRH computer login from home: http://dhts.duke.edu/modules/dhts_home/index.php?id=3

Using Remote Access: https://vpn.duhs.duke.edu

To complete mandatory online course for use of LMS: http://www.hr.duke.edu/training/location/lms/index.php

Chapter 8: Faculty Development and Faculty Affairs

Faculty Development

The Department of Medicine (DoM) leadership team is committed to helping each faculty member to achieve his/her career goals and thereby strengthen the DoM. Below you will find information on:

- Mentoring, facilitating diversity supplement awards, and peer mentoring groups
- Appointments, Promotions and Tenure (AP&T) process
- Opportunities for leadership training

Mentoring

The great academic success of the Department of Medicine over the last 75 years is, in part, a reflection of a long tradition of outstanding mentoring among the faculty. The Department continues to be committed to ensuring that each faculty member – at all ranks, and whether engaged in clinical, translational or basic science research, clinical care, teaching, or administrative endeavors – receives optimal mentoring.

To achieve this goal, the DoM leadership continually strives to enhance its infrastructure, procedures, oversight, and resources.

Ideally, mentoring involves 1) providing mentees with basic information and skills; 2) establishing expectations, guidelines and benchmarks for both mentors and mentees; 3) making use of individual, group and peer mentoring techniques; 4) effective communication; and 5) easily accessible resources.

1. Basic information and skills

The Office of Faculty Development in the School of Medicine (SoM) provides excellent seminars and workshops on topics such as:

- Scientific writing
- Writing a grant; responding to a review
- Making a presentation
- Finding funding
- Promotion and tenure process
- Managing a team (research or otherwise)
- Research regulations/ethical conduct
- Professionalism/conflict management

Visit the SoM Faculty Development website (**http://facdev.medschool.duke.edu**) frequently for information about upcoming programs and for archived presentations on these topics.

2. Establishing expectations, guidelines and benchmarks
This process generally occurs through regular meetings of mentee and mentor(s). In addition, each faculty member should expect an annual review with his/her Division Chief (or designee) to review progress, provide helpful feedback, set expectations and goals, and make plans. The annual review is also an opportunity for a faculty member to provide feedback to the Division Chief.

If your division does not automatically schedule an annual review, be sure to request one.

3. Individual, group and peer mentoring
Most of us need multiple sources of mentoring and informal advice. Be proactive in getting what you need!

Resources include:

- Peer mentoring groups: the DoM facilitates the formation and maintenance of peer mentoring groups. Separate groups exist for faculty who identify themselves as following one or more career trajectory: a) Clinician/Clinician-Educator; b) Clinical/Translational Researcher; c) Basic Science Researcher; d) Administrator; e) Undifferentiated Junior Faculty. These groups tend to focus on junior faculty. In addition, there is a separate peer mentoring group of mid-level faculty.

  Faculty can join one or more peer mentoring groups at any time. For more information, see the DoM blog (http://news.medicine.duke.edu/?s=peer+mentoring), contact LaVerne Johnson-Pruden (lj.pruden@duke.edu, 919-681-6386) or Dr. Susan Gurley, PWIM Chair, (susan.gurley@duke.edu).

- Your Division Chief is ultimately responsible for ensuring that each faculty member in the division has access to the mentoring he/she needs.

- The Vice Chair for Faculty Development and Diversity can also provide information, advice, guidance, brainstorming, and help with career strategy. Contact LaVerne Johnson-Pruden, (lj.pruden@duke.edu; 919-681-6386) or Dr. Laura P. Svetkey, Vice Chair, (svetk001@mc.duke.edu)

- Minority Recruitment and Retention Committee (MRRC): Contact LaVerne Johnson-Pruden (lj.pruden@duke.edu; 919-681-6386) or Dr. Kimberley Evans, MRRC Chair, (evans122@mc.duke.edu)

- Program for Women in Internal Medicine (PWIM): Contact LaVerne Johnson-Pruden (lj.pruden@duke.edu; 919-681-6386) or Dr. Susan Gurley, PWIM Chair, (susan.gurley@duke.edu)

- The Department of Medicine blog, at http://news.medicine.duke.edu/

where this information and much more can be found under the "Faculty Development" tab.

- Virtual mentor tips: Every few weeks, the Vice Chair for Faculty Development and Diversity posts a new "pearl" on the DoM blog. These Virtual Mentor tips address everything from advice from seasoned investigators on how to write a winning grant to information on promotion and tenure, to advice on work-life balance, and many other topics. Look for the latest Virtual Mentor tip at http://news.medicine.duke.edu/; go to http://news.medicine.duke.edu/?s=virtual+mentor&submit.x=0&submit.y=6 for an archive of all of them. Feel free to submit your own tips to the Vice Chair (lj.pruden@dm.duke.edu; or laura.svetkey@dm.duke.edu).

- Find research mentoring "pearls" from faculty who have experience on review panels. See "Virtual Mentor" at http://news.medicine.duke.edu/?s=virtual+mentor&submit.x=1&submit.y=10

- **Samples of funded grant applications, including career development awards, diversity supplements, revised applications, etc.** Go to http://news.medicine.duke.edu/faculty-development-resources-and-support/ but note that login is required (click "start here" link)..

- **Other sample documents:**
  - Intellectual statement
  - Duke CV
  - Diversity section for training grant application
  - Etc.

- **Diversity supplements:** Eligible candidates include under-represented minorities or disabled, high school through faculty level. Supplements are attached to eligible principal investigators holding an NIH-sponsored research award with at least 2 years remaining. **More information:**

http://news.medicine.duke.edu/wp-content/uploads/2012/05/Diversity-Supplements_tips_31oct2013.pdf
and/or contact Dr. Laura Svetkey, Vice Chair for Faculty Development and Diversity (via LaVerne Johnson-Pruden (lj.pruden@duke.edu; 681-6386)** for information and assistance.

4. Effective Communication

Communication and information sharing is at the heart of all mentoring. Faculty members are encouraged to keep an open line of communication with their mentees as well as their own mentors. Whether sharing division news, new funding opportunities, hot topics in your field or social events for your group, helping each other stay informed is an effective way to help each other advance and improve.

To facilitate communication at all levels of the Department, the DoM has a communications director (Anton Zuiker, anton.zuiker@duke.edu; 919-613-4310). In partnership with the Chair and senior management, the communications director is responsible for implementing a communication strategy to improve the effective flow of information and news through the Department. Please contact Anton with any news items – about yourself or your mentee(s) – as well as suggestions for effective communication tools that will further promote mentoring.

The primary source of up-to-date information is the Department of Medicine blog at http://news.medicine.duke.edu/. Visit the blog daily to stay truly informed – in fact, make it your home page; it's where all the good stuff is! Notify Anton if you need information that is not posted there.

5. Additional resources

- **School of Medicine faculty development opportunities.** Go to **http://facdev.medschool.duke.edu**.: Workshops include:
  a. Collaborating with statisticians
  b. Mentoring the next generation of biomedical scientist
  c. Responding to a Grant Review
  d. Effective presentation skills
  e. and many more

- **Are you ready for your first RO1? Follow the "Path to Independence".**

The School of Medicine offers a new program designed to assist junior investigators in securing their first independent R01 funding.
See http://medschool.duke.edu/faculty/office-faculty-development/path-to-independence-program

- **Would you like the NIH to pay your student loans?**

If you're pursuing a research career, check out the NIH Loan Repayment Program (http://www.lrp.nih.gov/index.aspx). Next deadline: September 1, 2012.

- **Get stats advice for FREE!**

The Department has arranged for special access to statistical consultation. Make a request at: https://www.dtmi.duke.edu/for-researchers/quantitative-resources/biostatistics-core

- **Duke Medical Center Library resources**
  - **Learn how to use endnotes** – it will really pay off when writing papers and grants. There's a tutorial at http://mclibrary.duke.edu/tutorials-tipsheets/endnoteand/or contact Librarian Consultant Ginger Carden at (919) 660-1184.

  - **Learn how to use PubMed to its full advantage** – it can do more than you know! There's a tutorial at http://mclibrary.duke.edu/tutorials-tipsheets/pubmedand/or contact Librarian Consultant Megan von Isenburg at (919) 660-1131

- **Conduct a survey:** Free software at https://duke.qualtrics.com/ControlPanel/ where you can create, distribute, and analyze a survey! (Like surveygizmo or surveymonkey, but free!)

- **Improve your presentation skills:**
View the video at http://news.medicine.duke.edu/2012/03/mastering-science-and-public-presentations/

- **Hone your skills in critical appraisal of the literature:** Review the JAMA Users guide at http://jamaevidence.com/resource/520 **or** go to the Quick Reference at http://jamaevidence.com/content/3350327

Appointments, Promotion, and Tenure (AP&T)

For general information about procedures and requirements for Appointments, Promotion and Tenure (AP&T), refer to the following:

- The official School of Medicine Guide to AP&T at: http://medschool.duke.edu/faculty/faculty-apt-office

- A supplementary document tailored for the Department of Medicine (DoM), which provides information and answers to frequently asked questions about the AP&T process from the DoM point of view is at: http://news.medicine.duke.edu/wp-content/uploads/2013/09/Medicine-APT-faq-2013.pdf
- Chapter 9 of this DoM Faculty Orientation Guide for information about tracking a pending appointment or promotion in the Department of Medicine Database.

- Dr. David Pisetsky, Chair of the DoM AP&T committee.

Leaves of absence and tenure clock relief (see attachment below)

Policies governing leaves of absence, such as parental leave, family or personal medical leave, sabbatical, etc, are generally found in the Duke University Faculty Handbook (see link below).

When tenure track faculty takes extended leave, they may wish to request a temporary stop to the tenure clock. In addition, tenure clock relief may be available, with approval of the Chair, in the case of:

- "specialized experience or training approved by the department chair, when during such experiences, research publications and other tenure-related activities are expected to be significantly reduced or interrupted"
- "significantly increased administrative duties that were unanticipated at the time of tenure-track appointment, e.g. serving as acting division chief or establishing a new program."

Policies governing tenure clock relief are also found in the Duke University Faculty Handbook (see link below).
The relevant sections of the Duke University handbook are found at:

http://provost.duke.edu/wp-content/uploads/2013/09/FHB_Chap_4.pdf

However, policies in the School of Medicine and in the Department of Medicine may differ slightly from overall DU policy. In addition, each entity within the DoM (e.g., PDC, VA, etc) may have its own requirements and approval process for leaves of absence. Therefore, if you're planning a leave and/or would like to request tenure clock relief, it's best to discuss your plans with your division administrator, division chief, and/or the DoM Vice Chair for Faculty Development and Diversity.

Key Policies on Faculty Leaves and Time Away from Duke

SoM and PDC Leave Policies for Faculty 1C

Leadership Training and Opportunities

Multiple opportunities exist both within and away from Duke. Some current examples of leadership training include:

- Duke LEADER: Leadership Development for Researchers (formerly CSML), http://medschool.duke.edu/faculty/office-faculty-development/LEADER a multi-day course offered by the SoM Office of Faculty Development.
- The Chancellor's Clinical Leadership in Academic Medicine Program (C-CHAMP) provides education and training to support success, strengthen the pipeline for Duke Medicine's next round of leaders, and strengthen the institution and its culture through engagement and innovation.
- AAMC faculty development seminars include 3-day intensive experiences for early and mid-career women and for under-represented minorities. Contact PWIM (susan.gurley@duke.edu) or MRRC (kimberley.evans@duke.edu) to apply for DoM sponsorship.
- Executive Leadership in Academic Medicine (ELAM) is an in-depth program focused on preparing senior women faculty at schools of medicine, dentistry and public health for institutional leadership positions. Contact PWIM (susan.gurley@duke.edu) to apply for DoM sponsorship.

ELAM: http://medschool.duke.edu/faculty/office-faculty-development/elam

Gopen: http://medschool.duke.edu/faculty/office-faculty-development/gopen-writing-seminars

Grant Writers: http://medschool.duke.edu/faculty/office-faculty-development/write-winning-grants

Faculty Affairs

"Faculty affairs" refers to the policies, procedures and guidelines related to managing conflicts of interest, insuring the highest standards of professionalism, and responding to concerns about faculty behavior. These are explained below.

Conflict of Interest

Conflict of interest (COI) for the School of Medicine is handled through the Research Integrity Office (RIO).

The Department, Divisions, and individual faculty members are expected to adhere to the following procedures:

1. COI form: SoM/RIO requires that each faculty member complete a COI report from each year (in February). SoM/RIO will contact you about completing the form. DoM is usually 100% compliant at 60 days.
2. Management plans
    a. The COI form helps to identify those faculty who need a management plan for a potential conflict. RIO also cross-references industry disclosures and reviews grant abstracts. If RIO thinks there may be a conflict, they contact the faculty member to discuss whether a management plan is needed.
    b. If an individual faculty member needs a management plan, RIO develops and manages the plans.
    c. Management plans are kept on file in the Chair's Office, but faculty members are responsible for working with RIO to keep RIO informed about any new information that may require a change to the plans.
3. Identifying need for assessment or management plan
    a. In most cases, the individual faculty member is able to determine if a potential conflict exists. The COI form helps the faculty make this assessment.
    b. RIO sends the DoM a list of all faculty members who report no conflicts. The Department is expected to identify any members who may have an undeclared conflict (e.g., someone who's known to be on the pharmaceutical lecture circuit), and either discuss the need to report a potential conflict with the individual faculty member or ask ROI to address the concern with that faculty member.
    c. "Conflicts of clinical interest" do not necessarily get reported on the COI disclosure form. These conflicts occur when a faculty member receives money from a company that makes a drug or device that the faculty member prescribes clinically. If there is extensive use of the drug/device in question, there may be a review of that faculty member's clinical practice to ensure that clinical practice is in line with prevailing guidelines.
    d. If you have a question about whether something constitutes a potential COI, **ask**. It's each faculty member's responsibility to identify and disclose conflicts.

Professionalism and Misconduct

All Department faculty are expected to act professionally, equitably and respectfully at all times, especially when interacting with patients, staff, trainees, and colleagues. Likewise, all faculty are expected to uphold the highest standards of honesty and integrity with regard to conduct of research, financial management and reporting, adherence to regulations, and a wide range of other professional activities.

In instances of alleged misconduct, complaints can be brought to the Division Chief, Department Chair, Vice Chair for Faculty Development and Diversity, or the Office of Institutional Equity (OIE).

If necessary, OIE will make an initial assessment as to whether the alleged misconduct potentially violates Duke policy prohibiting harassment or discrimination. If there is a potential violation, OIE then investigates and makes a recommendation to the DoM Chair. If there is no potential violation of harassment or discrimination policy, then the DoM will make every effort to investigate and resolve the complaint through individual conversations between DoM leadership and the involved parties. If it becomes necessary to bring in additional expertise, an ad hoc committee will review the allegation.

Actions taken by the DoM in response to a complaint may be subject to appeal to the Dean of the School of Medicine. Duke maintains a strict policy barring retribution against someone who brings a complaint.

The School of Medicine Professionalism Policy and resources can be found at http://medschool.duke.edu/faculty/office-faculty-development/resources-faculty-professionalism

Summary of websites in this chapter

Faculty Development Office: http://facdev.medschool.duke.edu

School of Medicine Guide to AP&T: http://medschool.duke.edu/faculty/faculty-apt-office

DoM AP&T guide and FAQ:
http://news.medicine.duke.edu/wp-content/uploads/2013/06/Frequently-asked-questions-about-APT.pdf

Department of Medicine Blog:
http://news.medicine.duke.edu/

ELAM: http://medschool.duke.edu/faculty/office-faculty-development/elam

Gopen: http://medschool.duke.edu/faculty/office-faculty-development/gopen-writing-seminars

Grant Writers: http://medschool.duke.edu/faculty/office-faculty-development/write-winning-grants

The School of Medicine Professionalism Policy and resources can be found at http://medschool.duke.edu/faculty/office-faculty-development/resources-faculty-professionalism

Chapter 9: Department of Medicine Database (DoM Db)

Purpose

The Department of Medicine Database (DoM Db) is managed by the Vice Chair for Faculty Development and Diversity (Laura Svetkey). It includes data on faculty and fellows in DoM that allow us to assess the composition of the DoM faculty and fellows and to track and monitor the Appointments, Promotion and Tenure (AP&T) process. The database is programmed to communicate with other databases in the University, and to provide various reports on demand (see below). As for all databases, it's not perfect and reflects our access to timely, accurate information. Faculty are encouraged to notify Dr. Svetkey (contact info below) if they want to be sure that data about them are accurate or if they notice inaccurate data in any DoM Db reports.

Available Reports

The following reports are generated from the Department of Medicine Database (DoM Db) according to the schedule indicated and by request.

Report #1 – Composition of Faculty and Fellows

These reports provide information by individual faculty and fellow name, either overall or sorted by division. The faculty reports (1a and 1b) include the name, division, demographics, rank, track, date of current rank and years in current rank. The fellow reports (1c and 1d) include name, division, program, and demographics.

- Report 1a: Faculty Listing
- Report 1b: Faculty Listing by Division
- Report 1c: Fellow Listing
- Report 1d: Fellow Listing by Division

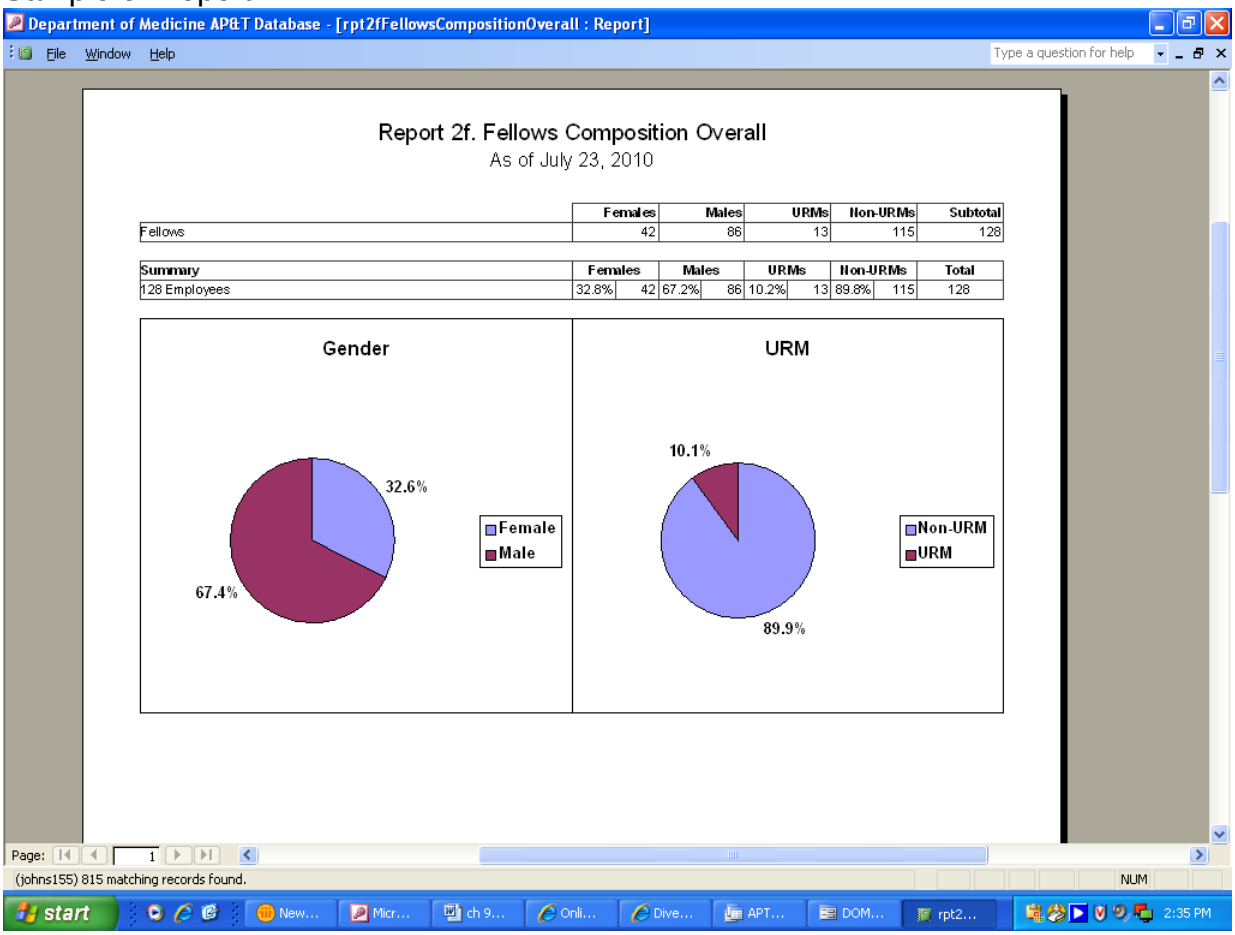
Distribution of Report #1: sent annually and on demand to DoM chair, AP&T chair, and division chiefs (division reports only)

Report #2 – Composition Summary

These reports provide a tabular and graphical summary of the distribution of faculty by division, rank, and demographic characteristics (sex and race). See sample below.

- Report 2a: Faculty Composition
- Report 2b: Faculty Composition within Division
- Report 2c: Faculty Composition Overall
- Report 2d: Fellow Composition
- Report 2e: Fellow Composition within Division
- Report 2f: Fellow Composition Overall

Sample of Report #2:



Distribution of Report #2: sent quarterly and on demand to DoM chair, AP&T chair, and division chiefs (division reports only)

Report #3 – Composition Over Time – (REPORT NOT YET AVAILABLE)
This report, to be developed, will allow us to track composition of the department (ie, data from Report #2) over time.

Employee Detail
This report summarizes demographics, rank, time in rank, tenure clock, and other information for individual faculty.

Distribution of Report: As requested by DoM chair, AP&T chair, or Division Chief (division data only).

Other Reports concerning AP&T:
The DoM AP&T Office (Angie Cain, 919-681-9803) will distribute periodic reports on the progress of individual faculty who are in the progress of being appointed or promoted.

Salary Equity Report
This report is generated by Dr. Gurley (Chair, PWIM) yearly and on request by the DoM Chair. It merges data from the DoM db with DoM salary data. It is used by Department and Division leadership to identify and address any patterns of inequity and outliers (high or low) that may occur.

Access to reports

1. Reports will be distributed as indicated above, but may also be obtained by authorized persons at any time by contacting LaVerne Johnson-Pruden (see below)
2. Faculty should contact Angie Cain (see below) if you have questions about your AP&T action.

Contact information

LaVerne Johnson-Pruden (lj.pruden@duke.edu, 919-681-6386) to request reports or for questions/corrections concerning your personal data.
Laura P. Svetkey, MD, MHS (laura.svetkey@duke.edu, 919-681-6386) for general questions about the database.
Angie Cain (angie.cain@duke.edu,919-681-9803) for questions about your progress through the AP&T process.
Chair of the DoM AP&T Committee (see chapter 2 for contact info) for questions about the AP&T process.

Chapter 10: Resources & Special Topics

Duke University

Overview: http://duke.edu/

Duke directory: http://www.oit.duke.edu/email-accounts/phonebook

Paging directory: http://pagingweb.oit.duke.edu

Duke University School of Medicine

Information for faculty and staff: an overview including links to the Duke University Faculty Handbook and the Faculty and Academic Affairs Procedure Manual where you will find information about Leaves of Absence and Tenure Relief, the Primary Care Giver Affidavit, as well as links to Training and Professional Development.
http://provost.duke.edu/faculty-resources/policies/

School of Medicine APT (Appointment, Promotion, and Tenure): overview with links to criteria and tracks for faculty in the clinical and basic sciences
http://medschool.duke.edu/faculty/faculty-apt-office

Department of Medicine Faculty Resources Library: variety of department resources (including AP&T Guide, this orientation packet, secure usage memo, Chair's recognitions, Grand Rounds archives, DoM calendar, etc.)
http://guides.mclibrary.duke.edu/content.php?pid=45306&sid=390173

General Information: a website presenting a long list of resources
http://medschool.duke.edu/faculty/duke-faculty-resources

- General information (appointment to graduate faculty, conflict of interest, faculty profiles, representation, etc.)
- Forms (CV, criteria for named chairs, faculty recruitment request, offer letter templates, HR forms, etc.)
- Benefits (HR, Duke advantages)
- Continuing education (office of CME, Duke tuition assistance, research ethics, etc.)
- Professional development (CRTP, clinical leadership program, mentored clinical research, etc.)
- Teaching resources (BlueDocs, gradebook, evaluation forms, etc.)
- Support services (offices of research administration, research support, sponsored programs; funding opportunities, compliance officer, IRB, IACUC, internal audit office, etc. including information on shared facilities)
- Other resources
- Centers and Institutes

Library: http://www.mclibrary.duke.edu

Office of CME: http://cme.mc.duke.edu/

Department of Medicine

Homepage: http://medicine.duke.edu

Leadership: http://medicine.duke.edu/about-department/administration-and-staff

Academic Departments:

http://medschool.duke.edu/about-us/academic-departments

Centers & Institutes:

http://medschool.duke.edu/research/centers-and-institutes

Duke University Health System (DUHS)

- **Main page:** http://www.dukehealth.org/
  - **Staff intranet:** http://intranet.dukemedicine.org/default.aspx
  - **Duke Medicine Intranet,** an exceptional employee portal: http://intranet.dukemedicine.org/default.aspx
- **Duke Medicine,** public pages: http://www.dukemedicine.org
- **Duke Health Technology Solutions (DHTS) Service Desk:** https://banquo.duhs.duke.edu/dhts/hdoutage.nsf?opendatabase
- **Emergency Management:** http://emergency.duke.edu/management/
- **Occupational & Environmental Safety:** http://www.safety.duke.edu/
- **Patient and visitor information:** http://www.dukehealth.org/patients_and_visitors

Private Diagnostic Clinic (PDC)

Intranet: https://intranet.dm.duke.edu/ent/pdc/SitePages/Home.aspx

Contains a large amount of information related to the PDC (including Human Resources, policy and procedures such as patient relations, information for physicians [including orientation, organization structure, key departments, member benefits/ policies/ procedures, etc.], information for managers (PDC employment policy, HR forms, personnel file forms, etc.), clinical information (patient safety, performance services, tools, etc.), Joint Commission, and HIPAA), and DPC (Duke Primary Care group).

Information for patients about the PDC: http://www.dukehealth.org/

Patient Revenue Management Organization (PRMO)

Intranet: http://intranet.dukemedicine.org/clinics/pdc/default.aspx

Finances

From the Office of Faculty Development, School of Medicine, Archived Events:
"Organizational Structure & Finances of the School of Medicine: Understanding How the Money Flows."
http://medschool.duke.edu/faculty/office-faculty-development/past-events

Duke@Work: MyProfile personal info, MyPay individual pay statements, MyResearch study financial reports, MyBenefits benefits selections, dFac faculty search & data, eCRT effort certification, etc. Requires the NetID for access.
work.duke.edu

Employee Travel & Reimbursement: To process all reimbursements and expenses, also with links for corporate travel and corporate credit cards. http://www.treasury.duke.edu/etr/index.html

Financial Services: Accounting, analytical, financial reporting: http://www.finsvc.duke.edu/

General Accounting Procedures: http://finance.duke.edu/accounting/gap/index.php

Benefits

Duke Personal Assistance Services: http://www.hr.duke.edu/pas/

Human resources:

Homepage: http://www.hr.duke.edu
Employee discounts: http://www.hr.duke.edu/benefits/discounts/
University benefits: http://www.hr.duke.edu/benefits

PDC member benefits: **http://intranet.dukemedicine.org/clinics/pdc/Lists/Human%20Resources/AllItems.aspx**

Diversity

Department of Medicine Faculty Development & Diversity: http://medicine.duke.edu/about-department/diversity

Department of Medicine Minority Recruitment and Retention Committee (MRRC): The DoM Minority Recruitment and Retention Committee: provides career mentoring, leadership development, social networking for under-represented minority faculty & trainees, and sponsors visiting lectureships: http://medicine.duke.edu/about-department/diversity/minority-recruitment-and-retention

Department of Medicine Program for Women in Internal Medicine (PWIM): The Program for Women in Internal Medicine provides career mentoring, leadership development, social networking for women faculty & trainees, and sponsors visiting lectureships.
http://medicine.duke.edu/about-department/diversity/program-women-internal-medicine

For more information, newsletters and related materials, visit the PWIM *wiki* located within Duke Wiki pages: https://wiki.duke.edu/display/PWIM/Home;jsessionid=2A7046C0581FF51B227FB45348AB6539

School of Medicine Multicultural Resource Center: Coordinates minority education, lecture series, scholarships, etc.: http://dukemed.duke.edu/modules/ooa_myedu/index.php?id=30

DUHS Diversity webpage: http://diversity.duhs.duke.edu/

Duke University Center for Lesbian, Gay, Bisexual, & Transgender Life: Contact Number: (919) 684-6607
http://www.studentaffairs.duke.edu/lgbt

Duke University Diversity webpage: http://medschool.duke.edu/about-us/office-diversity-and-inclusion

Duke University Office of Institutional Equity (OIE): The Office for Institutional Equity: provides institutional leadership in sustaining a respectful and inclusive environment. We provide a range of services to employees, managers, senior leaders and students that ensure access to employment and educational opportunities,

coordinate federal and state compliance efforts, and facilitate learning opportunities for all Duke employees. http://www.duke.edu/web/equity/index.html

Chief Diversity Officer: Judy Seidenstein
http://medschool.duke.edu/about-us/administration/judy-seidenstein
Judy Seidenstein was named the School of Medicine's first Chief Diversity Officer (CDO) in August 2011. In this inaugural role, she is focusing her efforts on the development and implementation of strategies to foster a culture of inclusion in which highly qualified students, faculty and staff from diverse talent pools experience a genuine sense of belonging, engagement and achievement. She has the responsibility for the development and management of a comprehensive strategy providing leadership, guidance and support across the school to conceptualize, define, assess and nurture the climate required for diversity, inclusion and excellence to thrive.

Additional Resources from the School of Medicine
Office for Faculty Development
Ann Brown, MD, MHS
Associate Vice Dean for Faculty Development

Office for Faculty Development

Contact Number: (919) 684-4139
http://facdev.medschool.duke.edu
The Faculty Development Program offers services and resources to support successful career navigation and development for all faculty in the School of Medicine. Based in the Office of the Dean of the School of Medicine, this program works in collaboration with departments and other schools at Duke to assess faculty needs and develop programs to address those needs. The website lists upcoming programs and personnel as well as slides from archived events.

Research Core Curriculum
http://medschool.duke.edu/faculty/office-faculty-development/research-core-curriculum
Series of seminars that provide a core of information for building a research career.

Duke LEADER: Leadership Development for Researchers (formerly CSML)
http://medschool.duke.edu/faculty/office-faculty-development/LEADER
Interactive 3-day workshop designed for junior faculty who are beginning to lead a research group. Must apply for selection.

ELAM
http://medschool.duke.edu/faculty/office-faculty-development/elam
The Hedwig van Ameringen Executive Leadership in Academic Medicine® (ELAM®) Program for Women is the nation's only in-depth program focused on preparing senior women faculty at schools of medicine, dentistry and public health for institutional leadership positions where they can effect positive change.

Faculty Handbook
http://provost.duke.edu/faculty-resources/policies/
This website contains information on policies such as the flexible work arrangement, parental leave, tenure clock extensions, and other information for faculty.

Also please see
http://www.provost.duke.edu/faculty/diversity/

Medical Center Library
Contact: (919) 660-1100
http://www.mclibrary.duke.edu/

The Medical Center Library (MCL) provides physical and electronic research resources to all students, faculty, and staff within the medical center. The Library also offers classes and training sessions on how to use research databases, tools, and technology.

Private Diagnostic Clinic
http://intranet.dukemedicine.org/clinics/pdc/default.aspx
The Private Diagnostic Clinic combines the professional medical services of the physician partners of the Private Diagnostic Clinic with the services and expertise of the Duke University Medical Center and Health System, and the Duke School of Medicine. Together these organizations provide expertise and experience in every recognized medical specialty.

Duke University Benefits
Contact Number: (919) 684-5600
http://www.hr.duke.edu/benefits
Duke University Benefits is a component of Duke Human Resources that is responsible for providing benefit information for Duke Employees.

Live for Life
Contact Number: (919) 684-3136
http://www.hr.duke.edu/about/departments/liveforlife/index.php
Live for Life is Duke University's employee health promotion program. *Live for Life* is a contracted service and is available to most Duke employees.

Institutional Review Board (IRB)
Contact Number: (919) 668-5111
http://irb.duhs.duke.edu/
The Institutional Review Board is responsible for the approving, monitoring, and reviewing of biomedical and behavioral research involving human subjects with the aim to protect the rights and welfare of these subjects.

Institutional Animal Care and Use Committee (IACUC)
http://vetmed.duhs.duke.edu/IACUC.html
Duke University acknowledges that animals used in biomedical research and education should receive the best possible care and be treated with respect. IACUC is responsible for ensuring the ethical use of laboratory animals in research.

Duke Office of Continuing Medical Education
Contact Number: (919) 401-1200
http://cme.mc.duke.edu/
The purpose of the Office of Continuing Medical Education is to collaborate with faculty, clinical departments, and other units to identify educational needs and to design, implement, evaluate, and document educational conferences and initiatives.

Office of Appointments, Promotion and Tenure (APT)
Contact Number: (919) 684-2927
http://medschool.duke.edu/faculty/faculty-apt-office
This office is responsible for providing information on the School of Medicine's rules and regulations, the APT process, and information on leaves of absence and leave policies.

Office for Institutional Equity
Contact Number: (919) 684-8222
http://www.duke.edu/web/equity/
The Office for Institutional Equity provides institutional leadership in sustaining a respectful and inclusive environment. The office also provides a range of services to employees, managers, senior leaders, and students that ensure access to employment and educational opportunities, coordinate federal and state compliance efforts, and facilitate learning opportunities for all Duke Employees.

Center for Lesbian, Gay, Bisexual, & Transgender Life
Contact Number: (919) 684-6607
http://www.studentaffairs.duke.edu/lgbt
The mission of the Center for Lesbian, Gay, Bisexual, and Transgender Life (Center for LGBT Life) is to provide education, advocacy, support, mentoring, and space for lesbian, gay, bisexual, transgender, transsexual, questioning, and straight-allied students, staff, and faculty at Duke, as well as alumni and members of neighboring communities. Through its services, the Center for LGBT Life presents educational, cultural, and social opportunities to challenge intolerance and promote affirmation, thus creating a more hospitable campus climate.

Multicultural Resource Center
Contact Number: (919) 684-5882
http://dukemed.duke.edu/modules/ooa_myedu/index.php?id=30
The Duke Multicultural Resource Center coordinates a variety of programs to help medical students, house-staff, and faculty work and learn together more effectively in an increasingly diverse environment.

Personal Assistance Service
Contact Number: (919) 416-1727
http://www.hr.duke.edu/pas/index.html
Personal Assistance Service (PAS), Duke's employee assistance program, offers assessment, short-term counseling and referrals from a staff of licensed clinical social workers and psychologists to help resolve a range of personal, work and family problems. Services are free and confidential to Duke faculty, staff, and their immediate family members.

Office of News and Communications
Contact Number: (919) 684-2823
http://newsoffice.duke.edu/
The Office of News and Communications is part of Duke's Office of Public Affairs and Government Relations. It works with the news media and others to highlight the

activities of Duke's faculty, students and staff, both locally and throughout the world. The office is Duke's hub for campus news and events, scholarship and administrative issues.

Clinical Research Support Office
Contact Number: (919) 681-6665
http://crso.som.duke.edu/
The Clinical Research Support Office seeks to serve patients in the global community by providing sound administrative and financial infrastructure to support the finest integration of patient care, education, and research while respecting the needs of the human subject. The CRSO participates in the development of institutional policies regarding clinical research, provides training and education to study teams and the clinical research community at Duke, and reviews and approves charge assignment grids.

Duke School of Medicine Basic Science Research Website
http://basicscience.medschool.duke.edu
At this new site, you will find links to core facilities, biomedical graduate programs, regulatory committees, training requirements, and many other areas of interest to investigators doing basic research.

ABC's of Duke School of Medicine Acronyms

APT	**Appointments, Promotions, and Tenure**
CME	**Continuing Medical Education**
CPOE	**Computerized Physician Order Entry**
CRSO	**Clinical Research Support Office**
CTBO	**Clinical Trials Billing Office**
DCRI	**Duke Clinical Research Institute**
DCRU	**Duke Clinical Research Unit**
DEDUCE	**Duke Enterprise Data Unified Content Explorer**
DHTS	**Duke Health Technology Solutions**
DN	**Duke Hospital North**
DS	**Duke Hospital/Clinic South**
DUHS	**Duke University Health System**

DUMC	**Duke University Medical Center**
IACUC	**Institutional Animal Care & Use Committee**
IDS	**Investigational Drug Service**
IRB	**Institutional Review Board**
L&OD	**Learning and Organizational Development**
MRC	**Multicultural Resource Center**
OCRC	**Office of Corporate Research Collaboration**
OESO	**Occupational & Environmental Safety Office**
OIE	**Office for Institutional Equity**
ORA	**Office of Research Administration**
OSP	**Office of Sponsored Programs**
PAS	**Personal Assistance Service**
PDC	**Private Diagnostic Clinic**
PRMO	**Patient Revenue Management Organization**
SOM	**School of Medicine**
SON	**School of Nursing**