MARSHALL UNIVERSITY SCHOOL OF MEDICINE
INTERNAL MEDICINE RESIDENCY TRAINING PROGRAM

LETTER OF AGREEMENT FOR THE COOPERATIVE TRAINING OF RESIDENTS/FELLOWS FROM MARSHALL UNIVERSITY JOAN C. EDWARDS SCHOOL OF MEDICINE (MUSOM), AND VETERANS ADMINISTRATION MEDICAL CENTER (VAMC)

This letter of agreement is an educational statement that sets forth the relationship between Marshall University School of Medicine (MUSOM) and Veterans Administration Medical Center (VAMC). This statement of educational purpose is not intended to supercede or change any current contracts and institutional affiliation agreements between the institutions.

This Program Letter of Agreement is effective from July 1, 2019, and will remain in effect for five (5) years, unless updated, changed, or terminated as set forth herein. All such changes, unless otherwise indicated must be approved in writing by all parties.

Persons Responsible for Education and Supervision

At MUSOM: Eva Patton-Tackett, M.D., Program Director

At VAMC: Samson Teka, M.D., Site Director and
All current MUSOM/VAMC Faculty Members (Exhibit A) which may change due to resignation or the addition of new faculty members

1. Responsibilities

The MUSOM faculty at the VAMC must provide appropriate supervision of residents/fellows in patient care activities and maintain a learning environment conducive to educating the residents/fellows in the AOA/ACGME competency areas. The Faculty must evaluate Resident/Fellows performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment.

2. Content and Duration of the Educational Experiences

The content of the educational experiences has been developed according to AOA/ACGME Residency/Fellowship Program Requirements and are delineated in the attached goals and objectives for each rotation. See Exhibit B.

The Program Director, Dr. Eva Patton Tackett is ultimately responsible for the content and conduct of the educational activities at all sites, including VAMC. The MUSOM Program Director/VAMC Site Director and the faculty are responsible for the day-to-day activities of the

Residents/Fellows to ensure that the outlined goals and objectives are met during the course of the educational experiences.

Rotations may be in two (2) week blocks, but generally rotations are a month in duration.

The day-to-day supervision and oversight of Resident/Fellow activities will be determined by the specialty service where they are assigned. The Program Coordinator, is responsible for oversight of some Resident/Fellow activities, including coordination of evaluations, arrangement of conferences, sick leave and annual leave as mandated by MUSOM.

3. Assignments

In accordance with the Affiliation Agreement between MUSOM and VAMC, MUSOM will provide to VAMC, the name of the Resident(s)/Fellow(s) assigned to the site, the service they will be training on and other relevant information.

4. Responsibility for supervision and evaluation of residents

Resident/Fellows will be expected to behave as peers to the Faculty, but be supervised in all their activities commensurate with the complexity of care being given and the Resident/Fellow own abilities and level of training. Such activities include, but are not limited to the following:

- Patient care in clinics, inpatient wards and emergencies
- Conferences and lectures
- Interactions with administrative staff and nursing personnel
- Diagnostic and therapeutic procedures
- Intensive Care unit or Ward patient care

The evaluation form will be developed and administered by the Internal Medicine Residency Program. Residents will be given the opportunity to evaluate the teaching faculty, clinical rotation and VAMC at the conclusion of the assignment.

5. Policies and Procedures for Education

During assignments at VAMC, Residents/Fellows will be under the general direction of MUSOM's Graduate Medical Education Committee's and the Internal Medicine Residency Program's Policy and Procedure Manual as well as the policies and procedures of VAMC, including but not limited to, policies related to patient confidentiality, patient safety, medical records.

6. Authorized Signatures

Veterans Administration Medical Center

Samson Teka, MD, Site Director — Date: 6/7/19

Jeffery Breaux, MD
Chief of Staff — Date: 6-7-19

W. Michael Skeens, MD
Chief of Medicine — Date: 6-7-19

for Mr. Brian Nimmo
Director — Carrie Hensley MSN, RN — Date: 6/7/2019

MUSOM

Eva Patton-Tackett, MD
Program Director - MUSOM — Date: 6/7/19

Paulette S. Wehner, MD, DIO
Vice Dean for GME — Date: 6/13/19

Joseph Shapiro, MD
Dean — Date: 6/24/19

Exhibit B: Goals and Objectives
Inpatient Medicine
Internal Medicine Residency Program
Marshall University

Introduction

The Inpatient Medicine rotation accounts for a major portion of the categorical Internal Medicine training program. Residents on the rotation are responsible for the initial evaluation and subsequent management of patients admitted to the hospital under the guidance of an attending physician. Patient care is provided using a multidisciplinary team approach in which interns (PG1) are responsible for all aspects of patient care and are supervised by senior residents (PG2 or PG3). Residents will have graduated levels of patient care responsibility during residency (see Residency Manual for details).

Rotation Structure

The Inpatient Medicine rotation is provided at Cabell Huntington Hospital, St. Mary's Hospital, and the VAMC. The resident will be part of a hierarchical team consisting of an attending physician, one or two senior residents (PG2 or PG3), and two or three interns (PG1). There are also usually one or two third year medical students on the team with the exception of the VAMC rotation, where one or two fourth year medical students completing a subinternship in medicine are a part of the team. Patient care is provided by the team 24 hours a day, 7 days a week. Call structure and work hours follow the ACGME guidelines and are described in the Departments' Residency Manual. Specific duties of the resident at each level of training are also described in the residency manual.

Goals

1. To prepare residents to diagnose and manage patients with common medical conditions requiring hospitalization, including a working knowledge of clinical pharmacology and nonpharmacologic disease management. [Medical Knowledge, Patient Care]

2. To provide an environment that ensures self-evaluation and self-directed learning. [Practice-based Learning and Improvement]

3. To provide knowledge of and support to perform necessary procedures for hospitalized patients. [Patient Care, Medical Knowledge, Systems-based Practice]

4. To enhance knowledge, utilization, and understanding of common tests (laboratory, radiologic, etc.) used in hospitalized patients. [Medical Knowledge, Patient Care]

5. To ensure that the resident learns to write appropriate, accurate, and pertinent medical record documentation. [Patient Care, Interpersonal and Communication Skills, Systems-based Practice]

6. To ensure that the resident develops an understanding of the various systems of patient care necessary to facilitate a comprehensive care plan for the hospitalized patient. [Systems-based Practice]

8. By the end of the PG1 year, residents will understand basic electrocardiogram and chest x-ray interpretation measured through direct observation by their senior resident or attending physician. PG2 and PG3 residents will enhance these skills by the end of their training, demonstrating understanding of more complex studies, such as CT imaging, by serving as the "interpreter" of the study and measured by direct observation from the attending physician.

9. By the end of residency, residents will understand the use of common tests ordered for hospitalized patients as measured by their senior resident or attending physician through their ordering and utilization of these tests.

10. By the end of the PG1 year, residents will develop an understanding of the systems of care used in the hospitalized patient and use these systems of care under the direction of the supervising resident or attending physician. By the end of the PG2 year, residents will demonstrate their appropriate use of these systems directly measured through observation by the attending physician.

10. Throughout residency, the resident will maintain the highest level of professionalism in all aspects of patient care and their duties as a resident physician. Professionalism is expected from the very beginning, but methods to enhance this professionalism will be learned by the resident's direct observation of their supervising resident and attending physician.

Core Topics and Resources

The following list represents the top reasons for hospitalization as identified by the Agency for Health Care Research and Quality (AHRQ) in 2006. Because the general internal medicine inpatient rotation includes patients with a very broad range of problems, the resident should familiarize themselves with these core topics and others as they arise, building on their knowledge over time as well as keeping up on the latest developments in medicine. An excellent resource available to the resident electronically is Up to Date Online (www.uptodate.com or www.utdol.com). This resource is available through most computers at the medical facilities and can also be obtained through subscription.

1. Pneumonia
2. Congestive heart failure
3. Coronary artery disease
4. Acute myocardial infarction
5. Chest Pain
6. Chronic obstructive pulmonary disease
7. Cardiac arrhythmias
8. Asthma
9. Sepsis
10. Complications of procedures, devices, implants and grafts
11. Mood disorders (depression and bipolar disorder)
12. Urinary infections
13. Fluid and electrolyte disorders
14. Diabetes mellitus with and without complications

15. Skin infections
16. Gallbladder disease
17. Gastrointestinal bleeding
18. Hip fracture
19. Venous thromboembolic disease
20. Appendicitis

Educational Methods

1. Participation in direct patient care under supervision of a supervisory resident and attending physician.

2. Review of written medical documentation by the supervisory resident and attending physician.

3. Oral presentation of patient data both at the bedside and in the conference room to the hospital team and selected demonstration of physical exam findings.

4. Review of all medical testing information with the attending physician, which includes direct viewing, interpretation, and discussion of electrocardiograms and radiographs.

5. Formal written review of readmissions to the hospital.

6. Case presentations at both Mortality and Morbidity Conference and Morning Report.

7. Core readings for rotation.

8. Attendance at resident conferences.

9. Attending physician oral and written evaluation and feedback of resident performance.

Evaluation

The primary means of summative evaluation is based on the attending physician's written evaluation of the resident's performance at the end of the rotation. Attending physicians are asked to evaluate the resident in all of the ACGME core competency areas using the standard 9 point Likert scale for resident evaluation. Residents also evaluate one another using this same evaluation form and they are evaluated by the medical student working under them. Formative evaluation is an ongoing process throughout this experience, as outlined in the Educational Methods.