

# GUIDELINES FOR RESIDENT BACKUP COVERAGE

Department of Medicine

2009-2010

Note: These guidelines are reviewed annually

## I. Principles and Definitions

- A. The following are general guidelines only and may be modified to fit the circumstances.
- B. To preserve equity, coverage assignments will take into account the covering resident's other rotations as well as past extra duty.
- C. Whenever possible, coverage assignments will minimize impact on continuity clinics.
- D. *At-Risk* Schedule
  1. An *At-Risk* schedule will be created annually to provide coverage for illness, emergencies, or fatigue for identified services (III.A.1, III.A.2, IV.A.1, IV.A.2.)
  2. Should the *At-Risk* pool become depleted, as determined by the chief residents and/or Residency Office, residents may be asked to be *At-Risk* for time in addition to what they were initially scheduled.
  3. When possible, the *At-Risk* schedule will be preferentially replenished with individuals who were *At-Risk* the prior *At-Risk* block (so, 2 weeks of scheduled *At-Risk* followed by 2 weeks of potential jeopardy in the unlikely event that the *At-Risk* pool becomes depleted). This ensures that someone is available at all times to fill in for unscheduled absences, while allowing residents to plan, not only for risk, but also for the uncommon occasion where they might be needed to fill in due to a high number of absences.
- E. Short-Term Coverage
  1. Coverage is usually part-time and for an absence expected to last less than 36 hours.
  2. A different person covers each night.
  3. Coverage is generally for nights and weekends only, except for very unusual circumstances (see I.C.5. below).
  4. Coverage for nights and weekends may be arranged by Chief Residents by referring to the current *At-Risk* schedule.
  5. When daytime weekday coverage is required, or for any other unusual circumstance, Chief Residents must discuss arrangements with the Residency Office before proceeding. These arrangements may include pulling *At-Risk* residents or residents who are not on the current *At-Risk* schedule, as long as their absences on short notice during the daytime would not cause major scheduling conflicts-
- F. Long-Term Coverage
  1. Coverage for an intern or resident is full-time and usually for an absence expected to last longer than 36 hours; unless the senior resident and attending agree that the service only requires an intern's presence during night-time call.
  2. All plans will be developed in consultation with the attending from whose service the resident is being pulled and must have prior approval from the Program Director or his designee.
- G. An "extra" resident/intern (see III.B.1.a., III.B.2.a., IV.B.1.a., IV.B.2.a.) exists when more than the usual number of housestaff has been assigned to a rotation.

## II. General Procedures

- A. Short-term coverage (illness, emergency, or when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care).
  1. The chief resident needing coverage consults with the Residency Office.
  2. Residents *At-Risk* must be available by pager or cell phone-and are expected to be able to report to a facility within two hours of being called.
  3. The chief contacts the appropriate resident from the *At-Risk* schedule.
  4. The Medicine Residency Office will cancel the appropriate clinics.
- B. Long-term coverage (illness or emergency)
  1. The chief resident needing coverage consults with the Residency Office.
  2. The appropriate resident will be notified by either the chief resident or the Residency Office.
  3. The Medicine Residency Office will cancel the appropriate clinics.
  4. If a resident is pulled for more than 36 hours, the Chief Resident or Medicine Residency Office will contact the faculty attending from the affected service.

- C. Anticipated Absences: Conference Presentations, Fellowship, Residency, or Job Interviews
  1. Residents may be excused for up to four days on a call rotation.
  2. The resident requesting leave is required to arrange coverage for any missed call cycles (correspondence to colleagues to be copied to chief resident and Residency Office). For residents requiring coverage for anticipated absences, it is most successful to approach specific individuals regarding a trade or other accommodation, rather than sending a general email to the housestaff. Residents should look at Amion ([www.amion.com](http://www.amion.com)) to identify potential candidates that are not "must-fill" rotations with whom to arrange coverage for an anticipated absence.
  3. If the resident requesting leave is unable to arrange coverage, either the Residency Office or the Chief Resident may pull from the *At-Risk* schedule for up to two days.
  4. Coverage will not be provided for residents on consult services as outlined in III.A.3. and IV.A.4.

### III. R1 Backup Coverage

- A. When is a substitute R1 needed?
  1. One or more call nights on inpatient general medicine at UWMC/HMC/VA, UWMC Cards A, Heme/Onc, MICU; HMC MICU, Neuro; or HMC/UWMC Float.
  2. One or more shifts: UWMC Day Float; VA Day Float; HMC ER; UWMC ER
  3. Not for: HMC Geri, subspecialty consult services, or clinic block rotations.
- B. Who is At-Risk to provide coverage? In order of priority:
  1. If at all possible, canceling continuity clinics will be avoided.
  2. Short-term:
    - a. R1s on *At-Risk* schedule.
    - b. Any "extra" Medicine R1.
    - c. Subspecialty consult R1s (preferentially assigned to the same facility).
  3. Long-term:
    - a. R1s on *At-Risk* schedule.
    - b. Reassign any "extra" Medicine R1 (see I.F.).
    - c. HMC Geri (provide coverage within same hospital where possible).
    - d. Go to every third night schedule.
    - e. Clinic block resident (Primary Care interns before Seattle or Seattle/Boise Categorical interns)
    - f. Recruit R1 (if need will exceed six months).

### IV. R2 and R3 Backup Coverage

- A. When is a substitute needed?
  1. One or more call nights on: inpatient general medicine: UWMC/HMC/VA, HMC Cards, MICU; UWMC Heme/Onc; VA CCU, or HMC/UWMC/VA Float.
  3. One or more shifts on HMC ER (must have had previous HMC ER rotation).
  4. Not HMC Geri, FHCRC, HMC/UWMC/VA consult, or ambulatory rotations.
- B. Who is At-Risk? In order of priority:
  1. If at all possible, canceling continuity clinics will be avoided.
  2. Short-term:
    - a. R2s/R3s on *At-Risk* schedule.
    - b. Any "extra" R2/R3 (see I.F.).
    - c. R2/R3 from subspecialty rotation.
    - d. R2/R3 from ambulatory rotation.
  3. Long-term:
    - a. R2s/R3s on *At-Risk* schedule.
    - b. Reassign any "extra" R2/R3.
    - c. R2/R3 from subspecialty rotations.
    - d. R2/R3 from research rotations.
    - e. R2/R3 from ambulatory rotations.

### V. Special Situations

- A. When coverage comes from a pool of housestaff on subspecialty consult rotations:
  1. An attempt will be made to arrange coverage by an individual currently assigned to the hospital where coverage is needed.
  2. If on a one-month rotation the individual will usually be pulled for one-week maximum.
  3. If on a two-month rotation the individual will usually be pulled for two weeks maximum.