Guidelines for Resident Backup Coverage

Internal Medicine Residency
Department of Medicine

Principles: The following are general guidelines only and may be modified to fit the circumstances. To preserve equity, coverage assignments will take into account the covering resident's other rotations as well as past extra duty. Whenever possible, coverage assignments will minimize impact on continuity clinics.

Definitions: Anticipated Absences include maternity/paternity leave, conference presentations, interviews, vacations, and weddings.

Unanticipated Absences include illness, emergencies, or fatigue.

Residents At-Risk are free from assigned clinical duties and must be available by pager or cell phone to provide coverage for a colleague.

Short-Term Coverage is for an absence expected to last less than 48 hours and is generally for admitting cycles only.

Long-Term Coverage is full-time and usually for an absence expected to last longer than 48 hours.

An Extra intern/resident exists when more than the minimum number of trainees is assigned to a rotation.

Policy: Short-Term Coverage is arranged by Chief Residents utilizing the At-Risk schedule. When coverage is required for a non-admitting day or other unusual circumstance, Chief Residents must discuss arrangements with the Residency Office before proceeding.

All Long-Term Coverage plans will be developed in consultation with the Program Office.

Residents At Risk, must respond to calls/pages within five minutes and report to the appropriate facility within two hours of being pulled to cover.

Should the At-Risk pool become depleted, as determined by the chief residents and/or Program Office, residents may be asked to be At-Risk for time in addition to what they were initially scheduled. When possible, the At-Risk schedule will be preferentially replenished with individuals who were At-Risk the prior At-Risk block (two weeks of scheduled At-Risk followed by two 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.
Residents may be excused from an admitting rotation for up to four days if presenting at a conference, or three days if interviewing for fellowship, residency or a job. The resident requesting leave is required to arrange coverage the absence. If after a reasonable effort, the resident is unable to arrange coverage, the Chief Resident may pull from the **At-Risk** schedule to provide coverage.

Except in rare circumstances, back-up coverage is not provided for inpatient consult services nor outpatient services. Coverage is not provided, nor may the **At-Risk** pool be used for personal absences including but not limited to weddings, vacations, and family events.

**Procedures:**

**A. Short-Term Coverage**
1. The Chief Resident pulls as from At-Risk pool, and
2. Notifies the appropriate hospital operators, and
3. Updates the Pull Log, and
4. Sends e-mail to medchiefs@uw.edu detailing absence and pull
5. The Program Office updates www.amion.com and makes a note on the At-Risk schedule

**B. Long-Term Coverage**
1. The Chief Resident consults with the Residency Office
2. The pulled resident will be notified by either the Chief Resident or the Residency Office
3. If a resident not **At-Risk** is pulled, the Residency Office will contact the impacted service

**R1 Backup Coverage:**

**A. When is a replacement R1 needed?**
1. One or more days/shifts on
   a. Inpatient general medicine at HMC/UWMC/VA
   b. Day medicine at VA
   c. Night medicine at HMC/UWMC
   d. ER at HMC/UWMC
   e. MICU at HMC/UW
   f. HMC Neuro
   g. UW Heme/Onc or Heme/Onc Nights
   h. VA Cardiology
2. Not for subspecialty consult services, nor ambulatory rotations.

**B. Who is At-Risk to provide coverage? In order of priority:**
1. Short-term
   a. R1s on **At-Risk** schedule.
      i. Anesthesia R1s are covered by Anesthesia jeopardy pool.
      ii. Emergency Medicine UW R1s are covered by UW EM jeopardy pool.
      iii. Family Medicine R1s are covered by FM jeopardy pool.
      iv. Internal Medicine, EM Madigan, Psych & PM&R are covered by IM Risk pool.
   b. R2/R3s on **At-Risk schedule**.
   c. Any "extra" Medicine R1.
   d. Subspecialty consult R1s (preferentially assigned to the same facility).
2. Long-term
   a. R1s on **At-Risk** schedule.
      i. Anesthesia R1s are covered by Anesthesia jeopardy pool.
      ii. Emergency Medicine UW R1s are covered by UW EM jeopardy pool.
      iii. Family Medicine R1s are covered by FM jeopardy pool.
      iv. Internal Medicine R1s are covered by IM Risk pool.
      v. Psychiatry will attempt to cover with other Psych interns.
      vi. PM&R will attempt to cover with other PM&R interns.
b. Reassign any "extra" Medicine R1.

R2 and R3 Backup Coverage:
A. When is a substitute needed?
   1. One or more days/shifts/nights on
      a. Inpatient general medicine at HMC/UWMC/VA
      b. Day medicine at HMC/UWMC
      c. Night medicine at VA
      d. MICU at HMC/UWMC/VA
      e. HMC Cardiology
      f. HMC ER (must have had previous ER rotation)
      g. HMC Gerontology
      h. UWMC Heme/Onc
      i. UWMC Cards A
   2. Not for subspecialty consult services, nor ambulatory rotations.

B. Who is At-Risk? In order of priority:
   1. Short-term:
      a. R2s/R3s on At-Risk schedule.
      b. Any "extra" R2/R3.
      c. R2/R3 from subspecialty rotation.
      d. R2/R3 from ambulatory rotation.
   2. 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.

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 an one-month rotation, the individual will typically be pulled for one-week maximum.
   3. If on a two-month rotation the individual will usually be pulled for two weeks maximum.

Process: These guidelines are reviewed annually by the Medicine Residency Advisory Council

Revised: July 27, 2017
Reviewed by Medicine Residency Advisory Council: