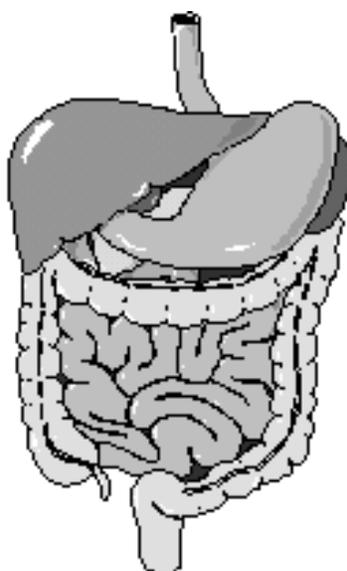


Fellows' Handbook
Division of Gastroenterology & Hepatology
University of North Carolina @ Chapel Hill
2011-2012



Division of Gastroenterology & Hepatology
4119B Bioinformatics Building
130 Mason Farm Road
The University of North Carolina at Chapel Hill
Chapel Hill, NC 27599-7080
(919) 966-2514

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UNC GI FELLOWS FOR 2010-2011

Ademola O. Aderoju, M.D.
 William J. Bulsiewicz, M.D., M.Sc.
 Seth D. Crockett, M.D., M.P.H.
 David J. Frantz, M.D., M.S.
 Jeffrey B. King, M.D.
 Christopher E. McGowan, M.D.
 Charles 'Brock' Miller, M.D.
 Marcus Muehlbauer, M.D., Ph.D.
 Farzad Nowrouzadeh, M.D.
 Joseph C. Onyiah, M.D.
 Eric S. Orman, M.D.
 Lena B. Palmer, M.D., M.S.C.R.
 Anne F. Peery, M.D.
 Shehzad Z. Sheikh, M.D., Ph.D.
 Kunwardeep S. Sohal, M.D.
 Laurie-Anne C. Swaby, M.D.

DIVISION OF GASTROENTEROLOGY AND HEPATOLOGY - FACULTY

John A. Baron, M.D., MSc, Professor of Medicine and Adjunct Professor of Epidemiology, jabaron@med.unc.edu; Colon Cancer Epidemiology and Prevention

Alfred S. Barritt, IV, M.D., M.S.C.R., Assistant Professor of Medicine, Pager # 216-0501, barritt@med.unc.edu; Liver Disease; Pre- and Post-Liver Transplantation

Eugene M. Bozymski, M.D., Professor of Medicine and Adjunct Professor of Medicine (DUMC), Pager # 123-1690, emboz@med.unc.edu; Clinical GI, Inflammatory Bowel Disease, Therapeutic Endoscopy; Esophageal Motility and Diseases

Ian Carroll, Ph.D., Assistant Professor of Medicine, ian_carroll@med.unc.edu; Intestinal Microbiota and Functional Bowel Disorders; Protease Inhibitors in the Treatment of IBS

Jama M. Darling, M.D., Assistant Professor of Medicine, Pager # 216-4955, jdarling@med.unc.edu; Viral Hepatitis, Liver Immunology, HCV-HIV Co-infection
Director, Hepatology Fellowship Program

Evan S. Dellon, M.D., M.P.H., Assistant Professor of Medicine and Adjunct Assistant Professor of Epidemiology, Pager # 123-4347, edellon@med.unc.edu; Eosinophilic Esophagitis, Advanced Endoscopy

Spencer D. Dorn, M.D., M.P.H., Assistant Professor of Medicine, Pager # 216-1797, sdorn@med.unc.edu; Irritable Bowel Syndrome; Psychosocial Aspects of IBS; Outcomes and Cost Effectiveness in the Delivery of Patient Care
Medical Director, GI Medicine Clinic

Douglas A. Drossman, M.D., AGAF, Adjunct Professor of Medicine and Psychiatry, 919-360-1234 (cell); 919-929-7990 (practice), drossman@med.unc.edu; Irritable Bowel Syndrome, Psychosocial Aspects of IBS

Michael W. Fried, M.D., Professor of Medicine, Pager # 216-2107, mfried@med.unc.edu;
Liver Disease, Hepatitis
Medical Director, UNC Liver Program; Director, Greensboro Hepatitis Clinic; Deputy Director, Translational and Clinical Sciences Institute (TraCS)

Lisa M. Gangarosa, M.D., FACP, AGAF, Professor of Medicine, Pager # 216-4504, lisa_gangarosa@med.unc.edu; Clinical GI, GI Malignancies, EUS, Therapeutic Endoscopy

Ian S. Grimm, M.D., FACP, AGAF, Professor of Medicine, Director – GI Procedure Unit, Pager # 123-4659, isg@med.unc.edu; Clinical GI, Liver Disease, Pancreaticobiliary Disorders, Therapeutic Biliary Endoscopy, EUS
Director, UNC Endoscopy Center

Jonathan J. Hansen, M.D., Ph.D., Assistant Professor of Medicine, Pager # 216-1802, jjhansen@med.unc.edu; Inflammatory Bowel Disease

Paul H. “Skip” Hayashi, M.D., M.P.H., Assistant Professor of Medicine, Pager # 216-2638, paul_hayashi@med.unc.edu; Liver Transplantation (particularly outcomes and organ allocation); Drug-Induced Acute Liver Failure and Injury; Hepatocellular Carcinoma (particularly risk factors, treatment and transplant outcomes).
Director, Liver Transplantation

Susan J. Henning, Ph.D., Professor of Medicine and Cellular & Molecular Physiology, sjhennin@med.unc.edu; Intestinal Development and Gene Therapy; Intestinal Stem Cells
Associate Director, Office of Medical Student Research

Hans H. Herfarth, M.D., Ph.D., Professor of Medicine, Pager # 216-4654, hherf@med.unc.edu; Inflammatory Bowel Disease; Nutrition; Celiac Sprue

James S. Heymen (Steven), M.S., Ph.D., Research Instructor of Medicine, Pager # 123-4855, Steve_Heymen@med.unc.edu; Biofeedback Therapy – Functional Bowel Disorders
Director, Biofeedback

Kim L. Isaacs, M.D., Ph.D., Professor of Medicine, Pager # 123-4807, k Isaacs@med.unc.edu;
Clinical GI, Inflammatory Bowel Disease, Pharmacology, Therapeutic Endoscopy
Co-Director, UNC Multidisciplinary Center for IBD Research and Treatment;

Christian Jobin, Ph.D., Associate Professor of Medicine, job@med.unc.edu; Inflammatory Bowel Disease

Biljana Jovov, M.D., Ph.D., Associate Professor of Medicine, bjovov@med.unc.edu;
Esophageal Tight Junction Function and Structure in Health and Disease

Temitope O. Keku, Ph.D., Associate Professor of Medicine, tokeku@med.unc.edu; Polyp Prevention

Henry R. Lesesne, M.D., Professor of Medicine, Pager # 123-1298, jlesesne@aol.com; Liver Disease

Sidney E. Levinson, M.D., Professor of Medicine, Pager # 216-1081, selev@med.unc.edu.
Director, Meadmont Endoscopy Center

Millie D. Long, M.D., M.P.H., Assistant Professor of Medicine, Pager # 216-6448,
millie_long@med.unc.edu; Inflammatory Bowel Disease

Ryan D. Madanick, M.D., Assistant Professor of Medicine, Pager # 216-2492,
madanick@med.unc.edu; Refractory Gastroesophageal Reflux Disease Testing and Management; Extra-esophageal Gastroesophageal Reflux Disease; Esophageal Multichannel Intraluminal Impedance; Eosinophilic Esophagitis; Dysphagia/Esophageal Motility Disorders
Director, GI Fellowship Program

Scott T. Magness, Ph.D., Assistant Professor of Medicine, magness@med.unc.edu;
Basic Mechanisms of Stem Cell Biology with Emphasis on Translational/Clinical Applications

Douglas R. Morgan, M.D., M.P.H., FACG, Adjunct Professor of Medicine,
douglas_morgan@med.unc.edu; Epidemiology, H. pylori, Gastric Cancer, Dyspepsia, Esophageal Disease, GI Manifestations of HIV
Former and Founding Director, Latino Clinic

C. Thomas Nuzum, M.D., Professor of Medicine, Pager # 123-1662, tom_nuzum@med.unc.edu;
Clinical GI, Liver Disease

Geraldine Orlando, Ph.D., Associate Professor of Medicine, geraldine_orlando@med.unc.edu;
Esophageal Epithelial Cell Biology, with specific expertise in cell culture and volume regulation

Roy C. Orlando, M.D., Distinguished Professor of Medicine and Adjunct Professor of Cell and Molecular Physiology, Pager # 216-1050, rorlando@med.unc.edu; Esophageal Epithelial Defense in Health and Disease, specifically with respect to Gastroesophageal Reflux Disease and Barrett's Esophagus

Scott E. Plevy, M.D., Associate Professor of Medicine, Microbiology and Immunology, Pager # 216-3766, scott_plevy@med.unc.edu; Diagnosis, Treatment and Management of Crohn's Disease and Ulcerative Colitis
Director, Immunotechnology Assay Core

David F. Ransohoff, M.D., Professor of Medicine and Clinical Professor of Epidemiology, Pager # 216-2314, ransohof@med.unc.edu; Epidemiology, Colorectal Cancer

Yehuda (Udi) Ringel, M.D., Associate Professor of Medicine, Pager # 216-6525,
ringel@med.unc.edu; Brain Imaging - IBS

Robert S. Sandler, M.D., M.P.H., Distinguished Professor of Medicine and Adjunct Professor of Epidemiology, Pager # 123-4440, rsandler@med.unc.edu; Epidemiology, Polyp Prevention
Division Chief; Director, Center for Gastrointestinal Biology and Disease (CGIBD)

R. Balfour Sartor, M.D., Distinguished Professor of Medicine, Microbiology and Immunology, Pager # 123-1308, rbs@med.unc.edu; Inflammatory Bowel Disease
Director, UNC Multidisciplinary Center for IBD Research and Treatment; Co-Director, Center for Gastrointestinal Biology and Disease (CGIBD)

Yolanda V. Scarlett, M.D., Assistant Professor of Medicine, Pager # 216-2764, yolanda_scarlett@med.unc.edu; Anorectal Motility and Manometry
Co-Director, UNC GI Motility Laboratory

Nicholas J. Shaheen, M.D., M.P.H., Professor of Medicine and Epidemiology, Pager # 123-4806, nshaheen@med.unc.edu; Epidemiology, Endoscopy, Esophageal Motility
Director, Center for Esophageal Disease and Swallowing (CEDAS); Director, Office of Medical Student Research; Co-Director, UNC GI Motility Laboratory

Miranda van Tilburg, Ph.D., Assistant Professor of Medicine, Pager # 216-9896, Tilburg@med.unc.edu; Pediatric Functional GI Disorders

Paul B. Watkins, M.D., Professor of Medicine and Pharmacology, Pager # 216-6990, paul_watkins@med.unc.edu; Director of Clinical Trials Unit

William E. Whitehead, Ph.D., Professor of Medicine and Adjunct Professor of OB-Gyn, Pager # 216-9896, william_whitehead@med.unc.edu; Anorectal Motility – Functional GI Disorders
Director, Center for Functional GI & Motility Disorders

Steven L. Zacks, M.D., M.P.H., FRCPC, Associate Professor of Medicine, Pager #216-1679, szacks@med.unc.edu; Liver Disease; Pre- and Post-Liver Transplantation

Pediatric Gastroenterology

Katherine L. Freeman, M.D., Associate Professor of Pediatrics, Pager # 216-1737, katherine_freeman@med.unc.edu

Ajay S. Gulati, M.D., Assistant Professor of Pediatrics, Pager # 216-0116, ajay_gulati@med.unc.edu

Michael D. Kappelman, M.D., M.P.H., Assistant Professor of Pediatrics, Pager # 216-1421, michael_kappelman@med.unc.edu

Sandra D. Kim, M.D., Assistant Professor of Pediatrics, Pager # 216-9639, sandra_kim@med.unc.edu

Steven N. Lichtman, M.D., Professor of Pediatrics, Pager # 216-9260, steve_lichtman@med.unc.edu

GI PHYSICIANS and SUPPORT STAFF

Barritt, Sid	Sharron Jones	sharron_jones@med.unc.edu	3-9483
Bozyski, Eugene	Linda Miller	lcmiller@med.unc.edu	6-0140
Darling, Jama	Wanda Dukes-Harris	wanda_dukes-harris@med.unc.edu	6-3739
Dellon, Evan	Jennifer Canders	jcanders@med.unc.edu	3-9618

Dorn, Spencer	Denise Coleman	denise_coleman@med.unc.edu	6-0005
Drossman, Douglas	Christina Davis	christina_davis@med.unc.edu	6-0729
Fried, Michael	Sherin Smetana	smetana@med.unc.edu	3-6386
Gangarosa, Lisa	Tiffany Durham	krull@med.unc.edu	6-3997
Grimm, Ian	Shawn Dubuisson	sdubuiiss@med.unc.edu	6-2513
Hansen, Jonathan	Linda Miller	lcmiller@med.unc.edu	6-0140
Hayashi, Paul	Sherin Smetana	smetana@med.unc.edu	3-6386
Henning, Susan	Steve Kennedy	skennedy@med.unc.edu	6-2514
Herfarth, Hans	Linda Miller	lcmiller@med.unc.edu	6-0140
Isaacs, Kim	Linda Miller	lcmiller@med.unc.edu	6-0140
Lesesne, Henry	Steve Kennedy	skennedy@med.unc.edu	6-2514
Levinson, Sidney	Fern Jeremiah	Fern_Jeremiah@med.unc.edu	3-0785
Long, Millie	Linda Miller	lcmiller@med.unc.edu	6-0140
Madanick, Ryan	Jennifer Canders	jcanders@med.unc.edu	3-9618
Morgan, Douglas	Jennifer Canders	jcanders@med.unc.edu	3-9618
Nuzum, Tom	Steve Kennedy	skennedy@med.unc.edu	6-2514
Orlando, Roy	Jennifer Canders	jcanders@med.unc.edu	3-9618
Plevy, Scott	Taimi Dunham	taimi_dunham@med.unc.edu	6-4405
Ransohoff, David	Fern Jeremiah	Fern_Jeremiah@med.unc.edu	3-0785
Ringel, Udi	Denise Coleman	denise_coleman@med.unc.edu	6-0005
Sandler, Robert	Fern Jeremiah	Fern_Jeremiah@med.unc.edu	3-0785
Sartor, R. Balfour	Susie May	susiemay@med.unc.edu	6-0149
Scarlett, Yolanda	Denise Coleman	denise_coleman@med.unc.edu	6-0005
Shaheen, Nicholas	Shawn Dubuisson	sdubuiiss@med.unc.edu	6-2513
Weinland, Stephan	Christina Davis	christina_davis@med.unc.edu	6-0729
Whitehead, William	LaVerne Milliken	lmillike@med.unc.edu	6-6708
Zacks, Steven	Sharron Jones	sharron_jones@med.unc.edu	3-9483

Faculty Mentors

We have a faculty mentor program in place. Your mentor(s) will meet with you formally twice per year (December/June) to review your progress in our fellowship program. We now have a program in place that sends you notice that it is time to schedule an upcoming meeting with your mentor(s), <https://cgibd.med.unc.edu/gifellows/meetingconfirm.php>. You will receive reminders until this has been scheduled. After the meeting, your mentor(s) will furnish a progress report, made available to the Division Chief and to both the fellowship program director and coordinator, which will be used as part of your bi-annual assessment in our training program. Since mentors are assigned initially according to expressed research interest(s) and related background, your mentor may change as you develop different interests in the field of gastroenterology. For example, if you are focusing on liver, your mentor will be a hepatologist. You should go to your mentor for guidance in establishing a scholarly project. All fellows are expected to develop a research project (clinical or basic science) to be carried out in the second and third years. By the second year, you should be able to present your research plans to colleagues at a Thursday morning pathophysiology or Thursday afternoon research conference, in addition to formulating an abstract for oral or poster presentation at a national conference. Fellows within our research tracks (basic science and epidemiology) – with a concentration in research – are expected to produce at least one publication for submission to a major journal. Epidemiology fellows can present research plans and updates at our Wednesday afternoon epidemiology conference; basic science fellows can present research plans and updates at our any one of our four weekly lab meetings (Henning, Jobin, Plevy, Sartor). Our

mentors should help fellows refine oral and written presentation skills. Fellows have the opportunity to present at required didactics but can also take advantage of practice sessions we offer for DDW and our annual Research Competition Day. Over the past years, numerous projects carried out by our fellows have been published and presented at national meetings. Questions about our automated program should be directed to Mark Duncan, our applications analyst, at 3-3946, mduncan@med.unc.edu.

Fellows and Mentors:

Ademola Aderoju – Doug Drossman (lead), Michael Kappelman, William Whitehead
 Will Bulsiewicz – Nick Shaheen (lead), Evan Dellon, Ryan Madanick
 Seth Crockett – Nick Shaheen (lead), Evan Dellon, Robert Sandler
 David Frantz – Ryan Madanick
 Jeff King – Susan Henning
 Chris McGowan – Robert Sandler (lead), Paul 'Skip' Hayashi, Mike Fried
 C. Brock Miller – Kim Isaacs
 Marcus Muehlbauer – Balfour Sartor
 Farzad Nowrouzadeh – Kim Isaacs
 Joe Onyiah – Scott Plevy
 Eric Orman – Mike Fried
 Lena Palmer – Paul 'Skip' Hayashi (lead), Robert Sandler, Michael Kappelman
 Anne Peery – Nick Shaheen (lead), Evan Dellon, David Ransohoff, Robert Sandler
 Shehzad Sheikh – Scott Plevy
 Kunwar Sohal – Ryan Madanick
 Laurie-Anne Swaby – Jama Darling

Our faculty are distinguished and recognized, both nationally and internationally. We are fortunate to have the foremost IBD clinician and researcher in the nation, **Drs. Kim Isaacs** and **Balfour Sartor**, respectively, and one of the key IBS Centers in the world, co-directed by **Drs. Douglas Drossman** and **William Whitehead**, respectively. Dr. Drossman also heads the IBS Rome committees. Our CGIBD may be selected as a national repository for clinical IBD data. Drs. Drossman and Whitehead were awarded a five-year NIH Grant on Mind-Body Interactions and Health. This grant establishes a Gastrointestinal Biopsychosocial Research Center focused on the causes and treatment of functional gastrointestinal disorders.

Our IBD Center has been named a “Center of Excellence” by the Crohn’s and Colitis Foundation of America (CCFA). To this end, the Center provides advanced training in the care of inflammatory bowel disease patients to gastroenterologists throughout the nation. Our IBS Center has also been named a “Center of Excellence” by the American Neurogastroenterological and Motility Society (ANMS). Again, to this end, the Center provides advanced training in the care of functional bowel disease and motility patients to gastroenterologists throughout the nation.

Our UNC Liver Program has partnered with Moses Cone Health System to open a medical practice in Greensboro to treat the growing number of people with chronic hepatitis C. This practice is called ‘Medical Specialty Services’. **Dr. Michael Fried**, a national leader in the treatment of hepatitis C, is its Medical Director. Hepatitis C is a liver disease that kills 8,000-10,000 Americans a year; this number is expected to triple within the next 20-30 years. The disease infects an estimated

12,000 people in the Piedmont area. Medical Specialty Services is located in the Northwood Building across from The Moses H. Cone Memorial Hospital. It is open three days per week and staffed by our liver specialists.

Sidney E. Levinson, M.D., is the Medical Director of our UNC Endoscopy Center at Meadowmont, located at 300 Meadowmont Village Circle, Suite 335, Chapel Hill, NC 27517; phone 843-7200, fax 843-7136. UNC Healthcare has a web site, <http://www.nccolonscreen.org>, which provides information about our UNC Endoscopy Centers at UNC-Hospitals and at Meadowmont, including how to schedule a procedure at either location, prep instructions for procedures, how to make a referral to our GI Medicine Clinic and to our Liver Program, and directions to our clinic, endoscopy unit and to Meadowmont. Other links include: ASGE, AGA, American Cancer Society, CDC Screen for Life, National Colorectal Cancer Research Alliance, UNC Lineberger Comprehensive Cancer Center, our division web site, and UNC Healthcare's web site.

Dr. Nicholas J. Shaheen has become the first president of the newly formed North Carolina Society of Gastroenterology (NCSG), with the inaugurating meeting held on Saturday, March 24, 2007, at the Khoury Convention Center in Greensboro. This group is being formed by members of all four academic training centers in the state (Charlotte, Greensboro, Raleigh, Wilmington), in addition to interested private practitioners, to further education, training, and policy matters for gastroenterologists in North Carolina. Its agenda is similar to those groups having formed in New York, Texas, and Virginia. Our group plans to sponsor educational meetings and fellows' programs. Fellows are welcome to join NCSG as well as attend the yearly meeting, this year held over the weekend of February 26-28 in Pinehurst, NC. Dr. Shaheen kept this appointment for two years. Dr. Stanley Branch of DUMC is current president. Interested individuals should contact Virginia Sherron, program coordinator, at virginia.sherron@duke.edu. Dr. Shaheen also served as Chair of the ACG Research Committee from 2007-2009.

Recently, **Drs. Douglas Drossman, Nicholas Shaheen** and **William Whitehead** were appointed Fellows of the American Gastroenterological Association. Dr. Drossman was also appointed to the NIDDK Commission on Digestive Diseases subcommittee for functional GI and motility disorders as well as to the editorial board for *Neurogastroenterology and Motility*. Additionally, he was nominated for the AGA Mentor Research Scholar Award. Dr. Shaheen was named the Ray and Christine Hayworth Medical Alumni Distinguished Teaching Professor from the Medical Foundation of North Carolina. Dr. Whitehead was appointed to the planning committee of the NIH State of the Science Conference on the Prevention of Fecal and Urinary Incontinence. **Dr. Douglas Morgan** received the ASGE Capsule Endoscopy Research Award. Our newest faculty member, **Dr. Susan Henning** from Baylor, received the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN) Distinguished Service Award, the first Ph.D. (non-MD) researcher ever to receive it. We are proud that **Dr. Robert Sandler** is serving a three-year term as President of AGA.

Eight UNC gastroenterologists have been named to the list of America's Best Doctors: Eugene Bozysmki, Douglas Drossman, Michael Fried, William Heizer (retired), Kim Isaacs, Robert Sandler, Balfour Sartor, and Nicholas Shaheen. UNC fellowship graduate Joseph Kittinger, who practices in Wilmington, NC, was also named to the list.

Our Division and Center are proud to be recognized as the second-largest research facility on campus, next to Lineberger Cancer Research Center.

LATINO HEALTH INITIATIVE

Dr. Douglas Morgan was awarded a grant from the Glaxo Institute to study gastric cancer in Honduras. He directs our nascent Center for Latino Regional and Global Health at UNC. His research interests include the epidemiology of functional gastrointestinal disorders (FGIDs) and gastric cancer, and Latino digestive health. Dr. Morgan's UNC research team includes Paris Heidt-Davis (program manager), Lesby Castellanos (RA), Jacqueline Fajardo (RA), and collaborators Dr. Ricardo Dominguez, Dr. Loreto Cortes, and Dr. Rodolfo Peña.

Collaborations in Honduras and Nicaragua have rapidly evolved into research initiatives. In western Nicaragua, a collaboration developed with Drs. Rodolfo Peña and Loreto Cortes at the University of Nicaragua, León. Based on the regional clinical experience and the presence of an impressive epidemiology surveillance system, the first population-based study of FGIDs with the Rome criteria in Latin America was initiated. The Rome Foundation provided funding to study the prevalence of FGIDs in this Latino population and examine postulated risk factors, such as poverty, parasite burden, intimate partner violence, and war trauma related to the Sandinista revolution. Comparable FGID prevalence rates were observed, relative to western populations, with important risk associations. Comparative studies in the FGIDs in diverse populations can provide insight into disease etiology and pathophysiology.

In parallel, in Honduras, a collaborative relationship and friendship arose with Dr. Ricardo Dominguez, the sole gastroenterologist in western Honduras. It was clear that gastric cancer, the second leading cause of global cancer mortality, was distinct in the region, with probable genetic factors operative, based on the aggressive nature of the cancer in young patients. The region also provided a unique "epidemiology niche" for the rigorous investigation of gastric cancer. A seed grant from our CGIBD helped initiate the investigations and generated strong pilot data. This facilitated several other scientific sector grants (e.g., GIDH), ultimately leading to a career development award (K07). In a high-incidence region, our researchers hope to gain insight into gastric cancer epidemiology, ultimately moving towards a prevention program.

Our Medicine clinics have established specific care providers to treat our increasing Latino/a population, including Dr. Mauricio Cohen (cardiology), Dr. Doug Morgan (GI), Dr. Marco Alemán (IM), Dr. Rómulo Colindres (nephrology), Dr. Patricia Rivera (pulmonary), Dr. Alfredo Rivadeneira (rheumatology), and Dr. Benjamin Calvo (surgery – breast). This pan-Latino clinic is staffed by Claudia Rojas (manager) @ 6-5800, cerojas@med.unc.edu, and Mayra McCarty @ mmccarty@med.unc.edu. The number for our Bilingual Call Center is 3-6141; directions are provided in Spanish by calling 6-3464. Financial counseling can be obtained by calling 6-2211 (physician appointment) or 6-1234 (hospital appointment).

On Thursday, October 15, 2009, we hosted a forum with over 100 attendees on Hispanic-Latino Health & Latin America Global Health with representative collaborations across the UNC campus, including our Center for Latino Health, SOM Campos Program, UNC Health Care, Gillings School of Global Public Health and Infectious Diseases, UNC School of Nursing, Latin American Health Initiative, Carolina Latina/o Collaborative (CLC), and Program in Latina/o Studies of the UNC College of Arts & Sciences. Members of our team won first place for their exhibit at our Annual Multicultural Fair held on 6/23/10.

We are proud to announce that on 10/23/10 our UNC Center for Latino Health and Clínica Latina won the annual area Latino Diamante Award given by Diamante, Inc. Please visit www.diamanteinc.org to learn more about this worthy organization.

To visit our Global Public Health web site, visit <http://globalhealth.unc.edu>. The Co-Director for CLC is John Ribó, email jribo@email.unc.edu. Current information on our Program in Latino/a Studies can be found on their website, <http://english.unc.edu/latina-o/UNCLatResources.html>, or feel free to email the program director, Dr. María DeGuzmán, at deguzman@email.unc.edu. To learn more about global work at UNC, please visit www.global.unc.edu.

Niklaus Steiner, Ph.D., is the Director of our Carolina Center for Global Initiatives, located at 301 Pittsboro Street, Suite 3007 (Campus Box 5145) in the FedEx Global Education Center: phone 2-6855; fax 2-5375; <http://cgi.unc.edu>.

UNC is proud to host many outstanding programs throughout the country, including our Gillings School of Public Health (ranked # 1 followed by Harvard and Johns Hopkins), Dental and Pharmacy Schools ranked # 2, Nursing School ranked # 5, HIV Prevention ranked # 7, and Medicine ranked # 20. Our Department of Family Practice ranked # 1. UNC also consistently has top-rated programs in journalism, speech communications, business, and international government.

Our Children's Hospital is one of the nation's best children's hospitals. According to U.S. News Media Group's edition of "America's Best Children's Hospitals" (2010), N.C. Children's Hospital was listed ninth among those caring for children with respiratory disorders.

Awards to Faculty Presented by Fellows

Beginning in 2002, our fellows began to award faculty members for excellence in teaching and patient care. Dorothy Taylor, RN, (2002-2003) and Jennifer Timmons, RN, (2003-2004) are the recipients of the UNC Gastroenterology Fellows Award for Excellence in Nursing, given annually to a nurse who has made significant contributions to the fellows' educational experience, exhibited excellence in patient care, and encouraged a supportive and collaborative environment. The Excellence in the Teaching of Endoscopy has been named The Eugene Bozymski Award, after its first recipient, given to Dr. Ian Grimm in 2003. Likewise, The Excellence in the Teaching of Gastroenterology and Hepatology has been named The William Heizer Award, after its first recipient, given to Drs. Steven Zacks in 2003 and Lisa Gangarosa in 2004. Both awards are given annually to a faculty member who has made significant contributions to fellows' education by providing intellectually challenging and exceptionally coherent teaching, an exemplary dedication to patient care, and a supportive and collaborative atmosphere. Finally, the UNC Gastroenterology Fellows Award for Excellence in Mentoring is given annually to the faculty member of our division who has made significant contributions to the career development of fellows, given in 2003 to Dr. Nick Shaheen.

Summary of Past Awards:

Eugene Bozymski Award for Excellence in the Teaching of Endoscopy

2004-2005 Roshan Shrestha, M.D.
 2005-2006 Nick Shaheen, M.D., M.P.H.
 2006-2007 Ian Grimm, M.D.
 2007-2008 Lisa Gangarosa, M.D.
 2008-2009 Ryan Madanick, M.D.
 2009-2010 Nick Shaheen, M.D., M.P.H.
 2010-2011 Paul "Skip" Hayashi, M.D., M.P.H.

William Heizer Award for Excellence in the Teaching of Gastroenterology & Hepatology

2004-2005 Yolanda Scarlett, M.D.
 2005-2006 Steven Zacks, M.D., M.P.H.
 2006-2007 Hans Herfarth, M.D.
 2007-2008 Paul 'Skip' Hayashi, M.D.
 2008-2009 Jama Darling, M.D.
 2009-2010 Steven Zacks, M.D., M.P.H.
 2010-2011 Hans Herfarth, M.D., Ph.D.

UNC Gastroenterology Fellows Award for Excellence in Mentoring

2004-2005 Mark Russo, M.D., M.P.H.
 2005-2006 Doug Drossman, M.D.
 2006-2007 Eugene Bozymski, M.D.
 2007-2008 Nick Shaheen, M.D., M.P.H.
 2008-2009 Robert Sandler, M.D., M.P.H.
 2009-2010 Evan Dellon, M.D., M.P.H.
 2010-2011 Robert Sandler, M.D., M.P.H.

UNC Gastroenterology Fellows Award for Excellence in Endoscopy Nursing

2004-2005 Shelly Kutchma, R.N.
 2005-2006 Marty Martinez, R.N.
 2006-2007 Jennifer Timmons, R.N.
 2007-2008 Kristine Barman, R.N.
 2008-2009 Joyce Davis, R.N.
 2009-2010 Mila Kwak, R.N.
 2010-2011 Debra Davis, R.N.

UNC Gastroenterology Fellows Award for Excellence in Endoscopy Nursing

2008-2009 Anthea Darling, R.N.
 2009-2010 Laurie Powers, R.N.
 2010-2011 Martha Bausch, R.N.

UNC GASTROENTEROLOGY and HEPATOLOGY WEB PAGE

The current web URL for our division is <http://www.med.unc.edu/gi>. Should one have questions about our web site, s/he may contact Mark Duncan at 3-3946, mduncan@med.unc.edu. Our division web site contains sections for

- Centers of Excellence
- Fellowship Program information
- Patient resources – faculty list, clinical services, maps and prep instructions
- Referral forms to our GI Medicine Clinic and Endoscopy Unit
- Staff resources – amion link (our clinic calendars), journal club, faculty leave form, accounting, research, conferences and consent forms

We have tried to make our division web site as comprehensive and useful as possible. If a section requests a user name and password for specific access, please enter GasHep for the user name and UNCGI for the password. Since some of our physicians use the division web page as their home page, a link to WebCIS has been added to our website, located as the bottom item under the 'Faculty/Staff Resources' pull-down menu. We have also created a page on our website with links to documents and simple forms frequently used by members of the Division and the Program in

Digestive Health. The documents fall under several topics such as accounting, purchasing, travel, etc. The link to the information documents page is <http://www.med.unc.edu/gi/infodocs.htm>. Take a moment to review this page and bookmark it if you use or might use any of the documents. Please feel free to recommend similar additional documents or information topics you feel would be useful to members of the Division or Program by contacting Mark. We have also added a section on 'events' where we include conference updates. For changes to the 'events' section, please contact Fern Jeremiah at 3-0758, fern.jeremiah@med.unc.edu.

Dr. Joe Cassara, former GI fellow, allowed us to incorporate his personal resource page into our division web site, which serves as a highly useful clinical point of reference for both our fellows and attendings. Under the 'Faculty/Staff Resources' menu, select 'GI Fellows', where one is directed to a login page. The password is 'uncgifellow'. The GI fellows' handbook is one of the resource tools contained on this site. Additionally, the fellowship program administrator has created a folder 'GI Fellows' on our division J drive intended as a comprehensive point of reference tool for fellows in training. This folder contains over 450 files covering all aspects of GI and documents pertaining to the field and more specific to our division. Major areas include 1) clinic, 2) procedure, 3) division, 4) education, 5) fellowship, and 6) housestaff policy and procedure. These files contain many PowerPoint slide presentations given at our weekly clinical case conference, in addition to the resident LIFE curriculum. Since users must be granted permission to access this folder, please see the administrator if you are unable to access the J drive or if you can access the J drive but do not have permission to access the folder. The administrator considers this folder as an ongoing repository of orientation materials for all GI fellows.

Dr. David Frantz, also former GI fellow, created a web page for fellow physicians to utilize. This contains an extremely well thought out and planned resource of key features that one can refer to and save on his or her desktop for quick and easy reference. The address is www.unc.edu/~dfrantz. At this site one can access Webmail, WebCIS, directory, online forms (e.g. fax cover sheet), Citrix, yearly rotation schedule, monthly on-call schedules, GI fellows' handbook (long and condensed version), schedules of required conferences and topics (Journal Club, GI Grand Rounds, pathophysiology), TransChart, MELD, Micromedex, PACS, links to Health Sciences Library, McLendon Labs, RYOUON and AMION, Dr. Cassara's page, the fellows' section of our Division web page, our Division web page, and our UNC Functional and IBD Centers, including Anthea's page (Anthea Darling, IBD nurse), in addition to instruction on antirejection, narcotic taper, MiraLax prep, and low-sodium diet. There are also links to our four main professional societies: AASLD, ACG, ASGE, and AGA, with corresponding guidelines. The fellowship coordinator compiles and maintains this handbook (long-form); Drs. Brock Miller (content and sequence) and David Frantz (layout and design) have compiled and maintain a condensed version of this handbook, a practical 'mini-handbook'.

The fellowship coordinator also compiles and maintains our division employee phone list, to include the following information: 1) 4th Floor Bioinformatics; 2) Faculty & Fellows; 3) Staff; 4) Support Staff; 5) Health, Safety and Communications; and 6) Miscellaneous.

Our Center for Gastrointestinal Biology and Disease (CGIBD) has a website <http://gadmin.med.unc.edu/cgibd/>. This site contains information about the Center, individual pages for the Center's scientific cores, and links to the core use request database. Our division web resources include faculty along with clinical and endoscopic services, Journal Club, GI Procedure prep instructions including consent forms in Spanish and procedure request forms, and links to our Centers of Excellence sites completed to date (CGIBD, Functional Gastrointestinal Diseases Center, Liver Disease and Transplantation Center). Our home page contains updated information such as

the latest screening guidelines for colorectal cancer. Researchers can consult core facilities by going to <https://cgibd.med.unc.edu/coreuse/index.php>. For our attending calendar, we formerly used www.amion.com (IM Chief Residents still use this calendar). However, we have created our own calendar called RUON, which Fern Jeremiah maintains. This calendar is posted on our fellows' resource site at www.unc.edu/~dfrantz. Our Division also has specific web sites for our Functional GI Disease Center: www.med.unc.edu/medicine/fgidc; IBD Center: www.ibdunc.org or www.uncibd.org; and our Office of Medical Student Research: www.med.unc.edu/osmr.

In addition, our Division has a web site as part of the Department of Medicine web site at <http://www.med.unc.edu>. Katie O'Brien maintains the Medicine web site. Should you have any questions about this site, please contact her at katie_obrien@med.unc.edu, 3-6487. Our pages on this site are comprehensive and include information regarding specialty clinics, services offered, appointments, Centers of Excellence, and ongoing research projects, including clinical trials. Our Medicine Grand Rounds schedule can be found on our Medicine web site at <http://medicine.med.unc.edu>. Our School of Medicine Newsletter can be found at www.med.unc.edu/news. This site houses archives of past SOM newsletters, in addition to UNC Health Care news and resources, in addition to public affairs and marketing.

COMPUTER ASSISTANCE

In regard to computer issues, if one requires assistance within our Division or Center, s/he may contact Wayne Burgett at 3-8526, eburgett@med.unc.edu (cell 260-2619). If Wayne is unavailable, please email help-gi@med.unc.edu for assistance. In the past, we have contacted the School of Medicine Office of Information Systems (OIS) for computer matters; however, since we pay the Department of Medicine for computer assistance, we have been instructed to utilize the Department of Medicine in this regard. Our computer liaison for Medicine is Jim O'Neill, joneill@med.unc.edu, 3-7910. In the event one needs to contact OIS client user services, s/he can send an email to request@med.unc.edu / help@med.unc.edu or call 6-1325 (<http://help.med.unc.edu>). As of 7/1/09, OIS has decentralized its facility operations, to include an IT service on the 6th floor of Biomolecular, on the 1st floor of Bioinformatics (with an audiovisual team on the 2nd floor responsible for assisting with presentations in reserved conference rooms), and 63 MacNider. (IT services were formerly located in Wing B of the Medical School.) Those experiencing problems with Thunderbird or Outlook Imap mail may want to read about it at <http://help.unc.edu/760>.

If a fellow wishes to establish port connection for a laptop, s/he may visit <http://www.unc.edu/wireless> for information on which locations of campus are attached to the wireless network and how to configure your laptop. You will have to obtain a wireless card registered on the UNC network before you are able to connect without having to plug in. Some may require a 10 base T ethernet cable RJ45 connector, which we can obtain from OIS. If you wish to connect to our printer network server to print from our network printer in 1140 Bioinformatics, the information you need to set up is: HP Laser Jet 8000 N, the path drive \\intruder\cg_BW324, IP address 152.19.41.10.

If you need assistance with our web-based Clinical Information Systems (CIS), you may call the hospital Information Systems Delivery (ISD) help desk at 6-5647. Remember that, like other web-based applications, UNC uses Internet Explorer, not Netscape.

Fellows have their own laptop and projector to use for their weekly pathophysiology seminars on Wednesday mornings. These are kept in the bottom drawer of the filing cabinet in the fellows' space in room B027. The lamp for the projector is guaranteed to last 2000 maintenance free hours.

In the event this should go out—which it has in the past, suddenly and without warning—please notify the fellowship coordinator, who keeps a spare InFocus lamp on hand. The InFocus lamp for the fellow’s projector is for LP340/350, part number SP-LAMP-LP3E. The InFocus lamp for the CGIBD projector we use for the weekly fellows’ research seminar held on Thursday afternoons is for LP280/290, part number SP-LAMP-LP2E. The bulb for this series projector generally costs \$50 more than for the other model (\$385 versus \$329). However, the coordinator found a bulb for the fellows’ projector through Dell for \$296 with two-day delivery. Sites referred to for purchase through our division P-card include www.dell.com and www.store.infocus.com. If you need assistance in setting up the laptop and/or projector, you may contact Wayne Burgett.

If you are setting up the InFocus projector in room 4137 of Bioinformatics for our weekly epidemiology seminar (4-5 pm on Wednesdays), here are some tips to keep in mind:

- InFocus is always on first, before the computer.
- Push the feet to adjust for height.
- The white cable connects the projector to the computer (blue-blue). (Some people bring their own computer.)
- The black power cord goes to the power outlet in the center table.
- The computer internet cable goes from the table to the computer.
- The computer power cord goes to the power outlet in the center table.
- Focus by using the inner and outer rims of the projector.
- When turning the project off, do not unplug until the fans goes off because the fan cools it down.
- Please make sure that the laptop and projector are put back in their cases and not left unattended but are returned either to Dr. Sandler or Wayne Burgett.

Sometimes the view on the screen goes out; this may not be the bulb if the fan continues to run. In this case—as happens often—there is a loose connection, generally between the power outlet in the center table and the computer.

Because research fellows are provided individual laptops, the idea has been brought up to ask a drug representative if the clinical fellows can have a laptop for research purposes of their own. It can be difficult to concentrate in the fellows’ space and at home. The Health Sciences Library provides port access, with the literature right there. Thus far, a clinical fellow who needs to use a laptop for research purposes has asked an attending for use of a spare one. S/he has also used the one used for conferences, but this can be inconvenient because use is interrupted.

UNC Information Technology Services (ITS) offers a variety of educational activities, including instructor-led short courses, face-to-face workshops, symposia, and video clips, to make technology work better at school and at work. Check the URL for activity updates by going to <http://help.unc.edu/tracs>. Courses include customizing one’s desktop, reducing SPAM, managing Oracle calendar, learning about PowerPoint and Blackboard, use of digital cameras, WEB accessibility and design, SAS, and Java. ITS’s web site is <http://its.unc.edu>, phone 2-4357, email LearnIT@unc.edu.

Computer Use in Procedure Area: Our Hospital IT Services reviews our computers in the clinical fellows’ space (B027 GI Procedures) on a periodic basis to determine if they need to be replaced or updated for capacity. It is paramount that these computers be maintained, given that physicians now must rely on them to enter patient interim notes, consult notes, Rx and other medical orders,

page colleagues, and review/sign off on outpatient clinic notes and ProVation procedure reports. These computers are in constant use and are necessary both for efficient patient care and for HIPAA purposes. An adequate ratio of viable computers to number of users inhibits cross-sharing of log-in and passwords. Research fellows beginning clinical work bring their individual laptops to use; residents from within UNC can go up to the floors to utilize computers. Please remember that the fellows' space serves as a hub for consult attendings (both GI and liver) and their teams, which include fellows (both from within & visiting), residents (both from within & visiting), and medical students (again both from within & visiting). Any issues pertaining to the function of computers in the fellows' space can be directed to the nurse manager of GI Procedures at 6-0244, fax 6-8764, pager 347-0842.

THE VIRTUAL (UNIVERSAL) PAGER

Pager Number 123-7010 is the single consult pager number for GI medicine consults. It is not a real physical pager but is a pager number. To make your page beep when the "Adult GI Consult" pager is called do as follows:

From any hospital touch tone phone dial 6-1100 (if at a non-hospital phone dial 966-1100).

Enter 123-7010

Enter password (GI) – 44

Press 2 to change page status

Press 8 for being covered by

Enter your pager number (the one you want to beep when 123-7010 is paged.)

The person going off call is responsible for the changeover of the pager number. Please also page the person who is coming on to let them know that the pager has been turned over. During the day, if the medicine resident is first call for GI, the virtual pager can be assigned to that person. However, it is ultimately the responsibility of the GI fellow to make sure that there is a person at the end of the consultation beeper number. We also use pager 123-7020 for the liver consult service and 123-7045 for the biliary fellow. On 7/17/09 we instituted the ambulatory pager (123-7044) so that service providers can contact our clinic fellow for any outpatient-related questions or concerns.

Because of the Critical Test Result Policy approved by the Clinical Management Committee and the Medical Staff Executive Committee, each clinical area must have a backup mechanism for the reporting of critical abnormal lab results and radiologic findings when the ordering physician is not available, both during office hours and after. Our virtual pager number has been submitted to the CMC for this purpose.

There is a GI fellows' pager alias to alert fellows of the availability of less practiced procedures, such as variceal bleeds, liver biopsies, and PEG placements. Pager 123-5001 serves as a group number for this purpose. When this number is dialed, all fellows are paged. Pages do not occur simultaneously but rather in succession, based on seniority.

In March 2011, the Department of Surgery created a pancreatic consult pager: 123-7370. This also appears in WebXchange under 'pancreatitis consults'.

OTHER PAGER ISSUES

Fellows appointed to Housestaff are provided individual hospital calling card phone and PIN numbers; fellows appointed to Medical Staff are provided individual UNC calling card phone and PIN numbers.

In the past, pager receptivity has been a significant problem in the GI Procedures Unit in the basement of the main hospital. In the past, hospital telecommunications has implemented a three-phase plan in an attempt to upgrade and enhance pager receptivity in this area. If a fellow experiences any problems with pager receptivity—either in the basement of the hospital or elsewhere on the floors or outside the hospital area—please notify the fellowship program administrator at once.

If a fellow requests a new pager, the program administrator must notify the following areas:

1. Hospital Operator (via submitting a request to the hospital telecommunication forms directory update at <http://www.unch.unc.edu/directoryform.asp>).
2. Tonya Phillips of the hospital paging service (tphillips@unch.unc.edu) phone 6-2356, fax 6-7943.
3. Frances Crump, manager of Carolina Consult (6-4005), fcrump@unch.unc.edu.
4. Everyone in the GI division alias.

The program administrator requests under #1 above that incoming calls to the fellow's former pager number be forwarded to the fellow's new pager number. If a fellow is temporarily using another pager number with the intent to resume his current number, the administrator can email Tonya with a request to assign a 'pager covered by' message on temporarily. Once the fellow reverts to his or her regular pager, the administrator can ask Tonya to remove this message.

For 123 pagers, hospital telecommunications cannot reprogram an existing number with a new pager: all new pagers have preprogrammed numbers. However, one can leave a message on the old pager so that anyone who dials that number can be notified of the new pager number. This can be done by dialing 6-1100, entering your seven-digit pager number, press 1 to change greetings, say your greeting and then press the # key.

Fellows appointed to Housestaff are assigned hospital pagers through the Housestaff Office. Pagers used for Medical Staff were purchased with division clinical funds and were first ordered through UNC Telecommunications (Arch wireless alphanumeric) but have since been ordered through hospital telecommunications (Apollo wireless alphanumeric). The hospital pagers were purchased at a set price (\$166 per pager) with no subsequent monthly charge; UNC pagers do not cost as much but carry with them a \$7 per month user charge. Upon completion of our program, fellows must return pagers purchased by us to us and those distributed to them from Housestaff back to that office.

For hospital pagers, some fellows have reported that the clip has fallen off from the apparatus; in this case or for any repair, please see Tonya Phillips of hospital telecommunications per above or stop by to see her on the first floor of the Old Infirmary Building, next to the GME Office. The program administrator can provide batteries upon request.

For those who desire nationwide coverage, that individual would need to have a 216 pager through UNC Telecommunications. However, because this service costs \$55 per month (\$660 per year), the individual would have to pay for this service him or herself by contacting Mr. Bruce Garris at bruce.garris@usamobility.com. Otherwise, an option would be to do a 'frequency regional' request, which costs \$4 per request, in which, for the time spent away, the fellowship coordinator would need to know beforehand so that a requisition can be submitted. The requisition states when the individual is leaving, when returning, and where s/he is going. That way, Telecommunications knows when to turn the service on, when to turn it off, and in what corresponding region to activate it.

The web site for sending text messages is <http://directory.unch.unc.edu/webdirectory>. A more recent directory upgrade on 6-1-11 includes a feature that allows the sender to display special instructions limited to 240 characters (including spaces): hospital telecommunications 6-2354; hospital operator 6-4131.

Directories:

The UNC-CH online campus directory can be found at <https://my.unc.edu/portal>.

Email

All subspecialty residents appointed through Housestaff must use hospital email for professional and business purposes. The resident must not have another email account. The School of Medicine Office of Information Systems (OIS) will not establish a SOM email account for residents appointed through Housestaff. The resident should check email daily, once in the a.m., and once in the p.m. In the past, our GI fellows have decided it best not to correspond with patients via email; for this reason, we do not include a fellow's email address on our business cards. **If a fellow wishes to communicate with a patient via email, s/he must notify Steve Kennedy, the division HIPAA coordinator, so that you have approval to do this.** This is in compliance with UNC Health Care HIPAA mandates in regard to care provider-patient correspondence via email.

The hospital has a secured firewall for email traffic. The SOM, however, does not but has upgraded its security to the point satisfied by hospital requirements so that intercommunication of patient-sensitive information between the hospital and SOM can occur. No care provider is to email such information, however, outside of this domain unless through the HIPAA coordinator, per above. No fellow is to use an outside or home email service provider for professional purposes. This is how a series of viruses infiltrated the UNC system, causing much inconvenience, throughout 2003.

If you wish to check email from outside, go to <https://exchange.unch.unc.edu/exchange> for hospital email or <http://medicineexch.med.unc.edu/exchange> for SOM email and type your user name at the first prompt and your password at the second prompt. For a SOM account, you may have to supply the server domain name: oissomnt.

Fellows appointed through Medstaff use SOM email. Another way to check your SOM email account is by going to <http://wwwmail.med.unc.edu>. A SOM account can be established by going to <http://help.med.unc.edu> and click on 'email account request'. You must have an Onyen in order to do this. Please email help@med.unc.edu for any questions. In order to set up an Onyen, visit <http://onyen.unc.edu>. A PID (campus ID) number is required for this: <http://pid.unc.edu>.

UNC HEALTH CARE MISSION STATEMENT: OUR VISION AND OUR VALUES

Our vision is to become the nation’s leading public academic health care system. Leading. Teaching. Caring. Our values consist of our principles that guide our day-to-day behaviors: our decisions, our actions and our relationships with each other and with the people we serve. We care about **our patients and their families** – delivering quality health care and outstanding service is fundamental to everything we do – **our team** – attracting and retaining the best team members is of paramount importance to our health care system. We will do this by becoming the health care employer of choice and by providing a practice environment professionally satisfying and financially rewarding – **our community** – dedicating ourselves to finding ways to improve the health of all North Carolinians is central to our leading, teaching, and caring.

Our primary focus must be improving the health of our patients and meeting their needs with our service excellence: We will have a culture dedicated to service and to measurable accountability. We will be state-of-the-art in meeting patient needs.

We must deliver excellent service and operate leading programs: Patients will experience a seamless and sophisticated system of care that is efficient, of high quality, safe, and easy to navigate. Outstanding research programs will enable high quality patient care with the most recent medical advances. Students and trainees will enjoy a fully rounded and rich experience that integrates outstanding clinical care and leading academic research.

We must be deeply and broadly engaged with the people of North Carolina and the nation to meet their health challenges: We will be innovators in research, development, and implementation of new means for improving the health of North Carolinians and sharing that knowledge with a national audience. We will have collaborative partnerships with Rex Healthcare, AHEC, the health sciences schools, the State of North Carolina, employers, insurers, other health care providers and key constituencies. We will have clarity in our role as the state’s safety net institution and our role as a leader among such institutions across the region and the US.

We must maintain financial viability for the UNC Health Care System, with margins sufficient to support our mission. Financial viability will be a system-wide objective with specific expectations and accountabilities established for each component of the health care system. This financial viability and margin will come from continual improvements in our operations and from an explicit, unapologetic focus on productivity enhancement.

COMMITMENT TO CARING

UNC Health Care is dedicated to serving its clients by providing quality customer service. We strive for an encounter here to be remembered as an exceptional experience for each customer. Staff members work in a health profession, and therefore quality patient care should be their top priority. Given the consumer trend of our present culture – our “drive-through” mentality – individuals tend to desire immediate gratification. In terms of culture, one must also take into consideration regional differences. In the South, a wait may not be as long as it is perceived in the Northeast. In our Commitment to Care campaign, employees have been asked to identify those factors that have deterred exceptional customer service by personal experience. These include worker attitude, lack of accountability, too long of a wait, being ignored, being bounced from person to person, not

getting a clear answer from multiple sources, and a “live” person not being readily accessible. This latter is emphasized, given the technologically ‘modern’ age in which we live.

People tend to remember and report negative encounters, versus positive ones. Negative encounters are the ones that seem to leave an impression and incite an individual to report them to other individuals. Therefore, a first impression – either by phone or in person – is paramount and lasting, with usually only one chance at pleasing the customer. Individuals come to our medical complex already in a state of anxiety, frustration or anger, and these feelings – obviously understandable – must be deflected and counterbalanced. These individuals must be reassured and made to feel as comfortable here as quickly as possible. A staff member – either within our complex or outside of it in the greater community – should always represent our system with the utmost professionalism, as our system will be judged and reputed by our own action by those with whom we come into contact. In this respect, a part represents a whole, and the individual who judges is doing so in response to the one who represents the whole. Therefore, the initial exchange must be an ideally positive one. When greeting people either by phone or in person, a staff member should always smile and evoke a pleasant attitude. Demonstrating this helps put our visitor at ease and allay fears. A service provider’s reputation is determined by three factors: 1) word of mouth, 2) personal experience, and 3) information shared/gathered. An employee empowered with a sense of caring who shows an eagerness to help also shows why he or she is working in the health care setting in the first place. An empowered employee leads by example and does not wait for others to take the lead. An empowered employee with a sense of caring – setting aside clinical acumen – is in touch with the human dynamics and connection with the social interaction at hand, “Can I bring you some water or a blanket?”

How is customer quality measured? It is measured by clear information and communication, responsiveness, and courtesy. Although we may know our way around the medical complex, visitors do not. We need to provide proper indications (signage, maps), and, when asked, help them to find their way. Staff can maintain morale by engaging in a team approach and by recognizing that many of us spend more time here than at home and that, for the visitor, workers as a group are likened to a family, and that the hospital itself is viewed as a home – our home – into which we welcome the visitor as his or her home as well. The physical structures themselves do not make a hospital – it is the beauty of those who work within who ensure the success of a care facility. An empowered employee is one who goes beyond the scope of his or her job, for example, in leading a visitor to a desired location, even though this is technically not a part of the person’s core job. Such an employee is willing to go the extra mile by virtue of humanism, without expecting compensation in return for meritorious behavior.

The appearance of our medical complex is also of paramount importance, as this can make or break an initial impression. A medical complex is perceived by many as a sterile environment, with proper hygiene. What is the impression of a visitor who comes to our Center for the very first time and sees even one piece of garbage strewn on the ground? In this sense, all employees associated with the medical complex have their part to play in making the place look as attractive and appealing as possible. We must also keep a heightened awareness of our setting: visitors can overhear conversations among staff members – such conversations should remain among staff members, such that visitors are not privy to them. In our Commitment to Care campaign, we wish to give people hope so that UNC is their health care facility of choice, not of last resort. In this light, we aim to provide a comprehensive product that is equally proportionate in view of customer satisfaction on the one hand, and the quality of service we offer on the other. To date, we have striven to meet this goal by implementing programs on patient safety (page 22), a dress code policy for employees in the hospital setting (page 218), and making our medical complex tobacco free

(page 74). In addition, we have implemented a resident LIFE curriculum, which covers issues relating to resident fatigue, behavior, and performance, with reading and resources our fellows can refer to and utilize in this regard, citing institutional policies and available programs. The LIFE curriculum is part of the orientation materials for all GI fellows, developed by the fellowship program coordinator, located on our division J drive in their folder, GI FELLOWS.

The Commitment to Caring slogan is two-fold: people-service-quality, finance-growth-innovation. Tips for demonstrating CC behavior include:

- Make eye contact;
- Position yourself at eye level when in conversation;
- Whenever possible, sit when talking with patients and families;
- Assure privacy;
- Listen attentively;
- Ask questions and always be sure to ask if you need more clarity;
- Be sincere;
- Ask if there is anything else you can do.

To learn more about Commitment to Caring, visit http://intranet.unchealthcare.org/site/w3/hr_intranet/ctc.

JCAHO

Surveyors from the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) visited the UNC Health Care System from February 14th through February 18th of this year for our once-every-three-year survey. More so than in the past, surveyors sought out medical staff, residents, subspecialty residents, and nurses to ask questions about patient care. Below are ten key patient care issues related to JCAHO standards:

1. AVOID WRITING MED ORDERS THAT UTILIZE A DOSE RANGE

Last year we instructed medical staff in the JCAHO-compliant use of so-called “range orders” for medication dose and frequency. However, JCAHO recently informed us that our interpretation of the standards was not exactly the same as theirs. Therefore, we have updated our policy to reflect their most recent guidance, and the Clinical Management Committee (CMC) reviewed this policy:

- a. Continuous infusions (e.g. dopamine, dobutamine) that are titrated according to a physical exam sign such as blood pressure are permitted. The order should simply indicate how the dose is to be adjusted according to the change in the physical sign (e.g. “titrate to MAP 80-90”).
- b. Except as above, please do not write a dosing range order. Instead, write for a specific dose of medication and ask to be called if the dose is subsequently deemed inadequate or if the patient suffers an adverse effect that would require a subsequent lowering of the dose. This new procedure applies to all medication classes, including narcotic analgesics, and medications for nausea and vomiting, constipation, or agitation. If a clinician writes an order that includes a dose range, a pharmacist will adjust the order to prescribe the lowest dose in the range. In the case of orders not

adjudicated by a pharmacist, our nurses will be instructed to make the same adjustment to the order.

- c. Similarly, if a frequency range is written as part of a medication order, the order will be adjusted to the shortest written dosing interval (so if order says Q4-6 hrs prn, it will be recorded and carried out as Q4 hrs prn).

2. AVOID PROHIBITED ABBREVIATIONS IN HANDWRITTEN ORDERS

Last year we established “prohibited abbreviations” (the same safety standards apply to electronic orders, and both CPOE and the prescription writer in WebCIS now comply with our own internal list of prohibited abbreviations). Please continue to be vigilant at avoiding prohibited abbreviations – especially “QD”, “QOD”, and “cc” -- in your handwritten orders. The list of prohibited abbreviations is available on the Intranet at <http://www.unch.unc.edu/pharmacy/abbreviations.pdf> as well as on screensavers throughout our hospitals’ computers.

3. UPDATE THE PREOPERATIVE H&P BEFORE OUTPATIENT SURGERY

For patients undergoing outpatient surgery, a history and physical must be performed within 30 days prior to the surgery, and if the H&P is done more than 7 days prior, an update needs to be done within the 7-day period before surgery. Procedures are in place to ensure that the update is performed, signed and dated by a responsible clinician prior to surgery.

4. USE “TIME OUT” STICKERS TO DOCUMENT THE “TIME OUT” BEFORE PROCEDURES

This is an FYI to let you know that preprinted stickers have been prepared for use in the paper record to document the “Time Out” procedure for situations where there is not already a documentation trail (OR and areas that use conscious sedation already have a place on a form). The “Time Out” is a validated exercise to reduce adverse medical events by providing one last chance to make sure that proper patient, proper procedure and (when relevant) proper side of the body are all confirmed prior to surgery and certain other procedures. JCAHO expects the practitioners to perform a “time out” for all procedures except certain bedside “routine and minor” procedures such as venipuncture, peripheral i.v. line placement, insertion of an NG tube, or Foley catheter insertion. Any individual – doctor, nurse, PA/NP -- *who participates in the procedure* -- can sign the documentation. Thus, in general, in “procedure areas” a nurse can sign, but the MD/PA/NP should sign for bedside and exam room procedures.

5. SIGN VERBAL ORDERS

This goes for CPOE and written orders. Promptly sign verbal orders in CPOE or on paper for patients for whom you are primarily responsible, even if another member of your team or cross-coverage wrote one or more of the orders. For non-attendings: if you are not comfortable signing any specific order that you did not write, discuss the order and its implications for the patient with an attending; do not just move on and wait for the other person to sign.

6. REVIEW AND REVISE ORDERS WHENEVER A PATIENT CHANGES FROM ONE LEVEL OF ACUTY TO ANOTHER

With the advent of CPOE, we have made it possible for you to maintain a patient’s active orders whenever the patient is transferred from one level of acuity to another (floor-stepdown-ICU), regardless of whether the patient’s care is also transferred to another team

of doctors. As you know, the responsible physician should review and revise orders at the time a patient goes from one level of acuity to another. Please make sure that if you are the responsible physician taking over the care of a patient or continuing the care of a patient who is changing from one level of acuity to another, that you always carefully perform this review of orders. We randomly audit CPOE orders; if we find that orders are not being reviewed, we have no choice but to ask physicians to rewrite orders at the time of transfer.

7. **RESOLVE ALL OUTSTANDING ORDERS BEFORE A PATIENT IS DISCHARGED**
CPOE has also made it much more apparent when unexecuted orders remain for a patient who is designated for discharge. When you get ready to write a discharge order, please check first whether there are any orders not yet carried out, especially diagnostic tests or therapies. If there are orders that need no longer be carried out, please discontinue them. Orders that do need to be carried out before discharge should be expedited. If you reschedule an order for post-discharge (i.e. outpatient), please document that in the discharge summary.
8. **MAKE SURE THE PATIENT'S NAME AND RECORD NUMBER ARE PRINTED ON EVERY SHEET OF THE PAPER RECORD YOU USE**
For those records that are still on paper, each sheet must identify the patient by name and record number. Stamp it with the patient's card, or write it in.
9. **WRITE LEGIBLY**
This one is self-explanatory. Also, when you sign an order, print your name or your physician code with the signature.
10. **PAT YOURSELF, AND A COLLEAGUE, ON THE BACK**
We are privileged to be able to save lives, ameliorate chronic illness, and relieve suffering. But this is still hard work, sometimes made more difficult by the ever-increasing regulatory burden under which we labor. We appreciate your hard work on behalf of patients and especially the way you continue to support one another in this endeavor.

**Control Plan for Multi-drug resistant (MDR) Acinetobacter sp. in the SICU and 5 West
(7/30/08)**

Control Measures for Patients known to be colonized or infected with MDR acinetobacter

- 1) Place on Contact Precautions in a private room.
 - All personnel and visitors must wear an isolation gown tied at the neck and waist along with clean exam gloves to enter the room.
 - When exiting the room, remove the gown and gloves near the door and while still in the patient's room or at a hand hygiene station directly outside the patient's room, perform hand hygiene: either a 15 second handwash with bactoshield and water or use an alcohol foam (Alcare) or gel (Purell). When using alcohol-based hand rubs, apply an adequate amount (golf ball size of Alcare and dime size of Purell) to cover all surfaces especially between the fingers and around the nail beds and rub hands until the foam or gel dries.
- 2) Wear a surgical mask with eye protection when you:
 - Suction a patient
 - Perform any cough inducing procedure
 - Provide wound care that creates an aerosol

- 3) Designate equipment to the patient for the duration of their stay.
 - If you must use any shared equipment in the room such as an x-ray plate or portable ultrasound, thoroughly clean all surfaces of the equipment with Metriguard, Sani-cloth, or 1:10 bleach and water. If the equipment has touch screen controls, clean with 70% alcohol. Surfaces should appear wet after applying the germicide and allowed to air dry for at least one minute.
- 4) MDR-Acinetobacter patients will not be removed from Contact Isolation during the current hospital stay.
- 5) Patients will be cohorted in the SICU and Nursing staff will be cohorted with the MDR-Acinetobacter patients. This means that nurses who are taking care of the MDR-Acinetobacter patients do not provide care to other non-colonized patients in the SICU.
- 6) Medical staff should round and provide routine care to the non-colonized patients before they interact with the Acinetobacter patients.
- 7) Staff that enters MDR-Acinetobacter rooms must be limited to only essential care providers, this includes medical staff on rounds.
- 8) Daily Room Cleaning
 - Performed two times each day by Environmental Services.
- 9) When the patient vacates the room:
 - Dispose of any unused supplies or send with the patient.
 - Notify Environmental Services that it is an MDR-acinetobacter patient discharge.
 - Environmental Services will terminal clean the room two times and the curtains will be changed. After completion the room is ready for a new patient.
- 10) Strictly follow the Hospital Visitation Policy for management of patient visitors.
- 11) There is no indication for changing scrubs after caring for an Acinetobacter patients as long as the appropriate isolation attire is used and scrubs are not visibly soiled after the gown is removed.

Control Measures for SICU patients who are not known to have MDR-Acinetobacter

- 1) Place all patients not known to be colonized or infected with MDR-Acinetobacter on empiric Contact Precautions and follow the guidelines as listed above under numbers 1, 2 and 7.
- 2) Surveillance cultures for MDR-Acinetobacter will be performed once per week while the patient remains in the SICU.
 - Surveillance cultures consist of a tracheal aspirate for patients on a ventilator or a throat swab for a non-vented patient AND a wound swab (skin swab of axilla or groin if the patient does not have a wound).
 - Epi staff will enter the orders for the surveillance cultures in CPOE.
- 3) Upon transfer from the SICU, the patient remains on Contact Precautions until post-transfer surveillance cultures are confirmed as negative for MDR-Acinetobacter. Hospital Epidemiology will notify the Nursing staff when the patient can be removed from isolation.
- 4) Epi staff will monitor the need for surveillance cultures of patients transferred out of the SICU.

Epidemiology staff will work closely with the SICU and 5 West Nursing and Medical staff to monitor the implementation of this control plan. Contact Hospital Epidemiology at 966-

1638 Monday-Friday, 7:30 AM- 4 PM and after hours via pager 216-6652 for additional questions or problems.

UNC Health Care Patient Safety Goals

Goal: Improve the accuracy of patient identification.

- Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

Goal: Improve the effectiveness of communication among caregivers.

- For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

Goal: Improve the safety of using medications.

- Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
- Standardize and limit the number of drug concentrations available in the organization.
- Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

Goal: Improve the safety of using infusion pumps.

- Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

Goal: Reduce the risk of health care-associated infections.

- Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Goal: Accurately and completely reconcile medications across the continuum of care.

- During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

- A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

Goal: Reduce the risk of patient harm resulting from falls.

- Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks.

Celeste Mayer, Ph.D., R.N., is our patient safety officer for continuous quality improvement of care. She can be reached at 6-6008 (phone), 3-0139 (fax), CMayer@unch.unc.edu.

The hospital intranet includes an occurrence reporting system and intended goals for improved patient safety and satisfaction at <http://intranet.unhealthcare.org>. Census updates from Fiscal Year-to-Date are posted (generally at 96% capacity), in addition to results of patient surveys (inpatient generally at 66%, outpatient 78%). Surveys are managed by Healthcare-Focused Survey Services – Customer Satisfaction and Counseling, www.thejacksongroup.com, and conducted by Press Ganey, POB 7006, South Bend, IN 46699-0468.

Emergency preparedness with quick links and emergency response guides are found at <http://intranet.unhealthcare.org/hospitaldepartments/disaster>. Healthcare employees are required to take emergency preparedness modules for reappointment and as part of annual performance reviews. Codes are designated on the back of hospital ID badges and are included in our division master phone list.

Vaccinations for Adult Inpatients

In a recent Physicians' Newsletter (http://medicine.med.unc.edu/uncpa/Vaccination_09.26.06.pdf), the importance of adult immunization is emphasized, and physicians are encouraged to vaccinate certain adults during hospitalization. To this end, there is a new tool in CPOE to promote pneumococcal vaccination. That tool is now ready for release and should appear in CPOE on or about November 1st, 2006. Please remember to obtain a vaccine history for all inpatients aged 65 or older and order a pneumovax, unless contraindicated.

Please also order influenza vaccine for eligible inpatients aged 50 or older or deemed “high risk” (for details of immunization recommendations see <http://www.cdc.gov/mmwr/pdf/wk/mm5540-Immunization.pdf>).

Note that the WebCIS H&P template has been revised to make it very easy to record the vaccine history – in the “Past History” section, just check the appropriate boxes. Our medical staff appreciates your efforts to improve immunization rates for our adult inpatients.

Infection Control

Q. What resources are available when you have questions about infectious diseases or infection control practices?

- A. The Infection Control Manual is on the hospital INTRANET. An Infection Control Professional (ICP) is available 24/7 at 966-1636 (Monday-Friday, 7am-5pm) or by cell phone during evenings/weekends/holidays (218-2683). **For the needlestick hotline, call 6-4480.**
- Q. When should you wash your hands?
- A. Use an alcohol-based hand rub (if hands are not visibly soiled) or wash hands using an antimicrobial soap before and after patient contact, after glove removal, and after handling visibly soiled or contaminated items. Additionally, hands must be washed before eating, drinking and after using the toilet.
- Q. How do you clean patient care equipment such as blood pressure cuffs and stretchers that have contact with different patients?
- A. Wipe with alcohol or EPA-registered disinfectant (e.g. Vesphene II) between patient uses and when visibly soiled. Vesphene II should not be used on items children might place in their mouths.
- Q. How do you communicate to others that a patient has an infectious disease?
- A. An isolation precautions' sign is displayed in a visible location outside the patient's room. Additionally, the type of isolation is communicated by verbal report to another department when the patient is transported elsewhere and the information is on the Patient Factors Screen (Computer Information System).
- Q. What steps are taken to take care of patients with antibiotic resistant bacteria (for example, MRSA, VRE)?
- A. The patient is placed on Contact Precautions
- Private room
 - Gloves and hand hygiene
 - Gown if you anticipate contact with patient or environmental surfaces
 - Dedicate use of patient equipment when possible; clean and disinfect shared equipment after use
- Q. What do you do when the medication refrigerator checks are above/below the control limits?
- A. Contact the Pharmacy to assure that the contents are acceptable for patient use. If malfunction is suspected, contact Plant Engineering to check the refrigerator. Document your actions and follow up on the temperature chart.

UNC HEALTH CARE MEDICAL CODE OF CONDUCT

The medical faculty of the UNC School of Medicine is dedicated to providing the highest standards of medical service to the citizens of North Carolina and to all others within its care. Clinicians are subject and committed to ethical standards through membership in specialty societies and by becoming medical professionals. The medical code of conduct stated here focuses on our role as clinicians. We are equally committed to the values embodied in all applicable university policies that address not only our clinical activities but also our duties and responsibilities related to research and teaching. The medical faculty unequivocally endorses and supports the code of conduct of the UNC Health Care System.

Patient Care

- We provide the highest quality health care services without regard to race, color, sex, religion, national origin, age, sexual orientation, disability, or method of payment. We recognize a patient's right to participate in decisions involving his or her health care and uphold a patient's right to formulate advance directives concerning his or her health care.
- We value and respect the privacy of patients, limit access to patient information to those with a professional need to know, do not access such patient information without a professional need to know and safeguard medical records and other confidential patient information from accidental or intentional modification, destruction, or disclosure.

Billing for Services Rendered

- We bill, or cause to be billed, only services documented in the medical record to the full extent required for high quality patient care and in compliance with federal and state regulations and third-party payer contracts.

Audits and Investigations

- We cooperate with all government and approved internal audits and investigations, provide accurate information to internal and external auditors and investigators in accordance with legal requirements, and do not provide false information or destroy/alter any documents requested as part of an investigation or audit.

Work Environment

- We do all that we can to foster a positive work environment by respecting and supporting the nursing staff, residents, fellows, students, and other health care professionals/support staff.
- We will not use, sell, purchase, transfer or possess illegal drugs or misuse legal drugs while on university or UNC Health Care System property or transacting university or UNC Health Care System business and will not report to work impaired by alcohol or drugs, including drugs prescribed by a physician and over-the-counter medications.

Business Operations

- We recognize that cost efficiencies are essential for our ability to deliver health care services successfully. We are committed to identifying appropriate opportunities to reduce costs without compromising patient care.

Conflict of Interest

- Consistent with university policy and state and federal law, we avoid conflicts of interest in all aspects of our work as clinicians. We do not solicit or accept gratuities, bribes, kickbacks or illegal payments. We refer to University Counsel any questions that may arise concerning conflicts of interest or situations that could lead to illegal activity.

Violations of this code of conduct or of applicable university or UNC Health Care System policies could result in disciplinary action up to and including dismissal.

Questions concerning apparent breaches in the clinician code of conduct or the applicability of the code to a specific situation may be addressed by calling the Compliance Office at 3-8638 or

University Counsel at 2-1219. Those wishing anonymously to report concerns or alleged violations may do so by calling the Help Line at 1-800-362-2921, a special telephone answering service for anonymous reports pertaining to compliance. Employees, who report *in good faith* possible issues pertaining to compliance—either directly or through the Help Line—are protected by the university’s no reprisal policy and will not be subjected to retaliation or harassment as a result of the report.

On 4/20/09, UNC Health Care implemented a formal policy asking the uninsured for deposits, with two major goals in sight: a) set point-of-service (POS) payment expectations for the uninsured comparable to the insured patients who are expected to pay co-pays and co-insurance and estimated deposits at the POS, and b) by setting POS payment expectations and expecting payment at the POS, the uninsured no longer has an inadvertent payment advantage at the POS as a result of being uninsured. Patients without health insurance coverage are required to pay an estimated deposit for all clinic visits, including multiple visits per day and all diagnostic tests at check-in.

- For new visits: \$100 deposit
- For return visits: \$80 deposit
- For each lab, x-ray or other test: \$20 deposit

Patients who are active on UNC Charity Care plans are asked to make a co-payment at check-in.

- General Internal Medicine, Family Medicine, Children’s Primary Care: \$25
- Specialty care: \$35
- Lab, x-ray, or other test: \$20
- Ambulatory surgery: \$75

Patients are not to be turned away if they are unable to pay these amounts. Financial counseling is available to assist these patients.

- The financial counselor (FC) will explain payment requirements.
- The FC will collect as much of the payment as the patient is able to pay and set the patient up on a payment plan.
- The FC will screen the patient for other third-party funding, including Charity Care.
- The FC will provide the name and contact information for alternate healthcare facilities within the patient’s geographical area.

This program is intended to help offset increasing expenses associated with operating an ever expanding state-of-the-art tertiary care facility. Within the last 15 years, ungenerated revenue has risen from \$130,000,000 per year to \$340,000,000 per year, of which the State of NC provides \$44,000,000.

MEDICINE ADMISSIONS POLICY

The UNC-H Transfer Center has been operational since January of 2006. Under the leadership of Sharon Coulter James, Senior Vice President, and Jeffrey Strickler, Director, Emergency Services,

the Transfer Center was formed to accept transfer calls from referring hospitals and physicians for all clinical services in UNC Hospitals beginning July 1, 2006. Currently, the Transfer Center is accepting calls for ten services, 24 hours a day, seven days a week. Over the last two months, they have handled nearly a thousand calls. Calls are handled by our hospital operators (6-4131). Outside referrals call a toll-free number, 1-800-806-1968. Internal referrals call 3-1920.

The personnel manning the Transfer Center are physically located in Omaha, Nebraska. We are working with the highly respected national group, LifeCom, which has extensive experience in helping hospitals arrange transfers quickly and efficiently. This is a wonderful opportunity and an impressive challenge for all of us. The opportunity is that we can, for the first time, keep accurate records of our interactions with referring physicians and hospitals. We will also be able to collect data upon which we can make decisions about bed availability and really know how often we are unable to accept patients due to this or other issues. With the protocols being used by the Transfer Center, physicians who answer these calls will not have to make decisions based on bed availability or timing, for they can simply make the correct clinical decision and the rest of the details will be worked out between the Transfer Center and Bed Assignment.

In particular, we are focused on having faculty physicians answer all calls. This is certainly a change in culture, and an important one. Second, we need to be available to respond immediately when called by the Transfer Center. Third, we need to make prompt decisions - at the time of the first phone call. The major advantage in having faculty take these calls is that it will not be necessary for a resident to check with their attending as to whether they should accept the patient in question or not. The faculty will be on the phone. To this end, our goal is to have all calls answered promptly and a decision made quickly in regard to a patient's being accepted for transfer or not, and, if not, then for what clinical reasons. Pertinent background work will then be performed to determine when the patient can actually be transferred or whether they are appropriate for transfer based on level of care and admission criteria. All calls will be recorded for our protection and to document our responses. Again, as the Center is used more, over time we will be able to collect extensive data for future use.

As with many initiatives in the past year or two, our new Admissions Policy, with the establishment of our Transfer Center, remains a work in progress, yet a step towards greater efficiency and improved quality of patient care.

Specialty Admission and Resident Service: Our resident night floats have had some issues with information on patients arriving as direct admissions or through the ER at the referral of subspecialists. If one adds a patient to the medicine admission list, please leave a contact name and contact information so that if there are questions once the patient arrives, the appropriate resource can be contacted, as the brief descriptions on the medicine admission list are not always clear. There have also been instances when a dictated clinic note for a patient sent from clinic may not be available by the time the patient arrives so "see clinic note" under Comments may not be sufficient, further adding to the importance of available contact information. Moreover, there are patients who are referred or transferred to UNC from outside institutions who have never been to UNC before and consequently do not have medical record numbers. Because they do not have a MRN, they cannot be added directly to the list; however, they can be added as a TEST patient, which is a generic patient profile, and their information can then be given under Comments.

Effective Monday, November 1, 2010, at the request of Dr. Allen Liles and Priscilla Merryman, ISD is adding two (2) inpatient hospital services and modifying the MDH description. The hospitalist program volume has grown considerably over the last two years. In order to facilitate and improve nurse/physician communication, we are dividing the single large census into three

services. Each of these services will be staffed by a single attending only. Overall bed allocations for the Hospitalist program remain at 8 licensed beds, but will be distributed across the services:

MDH – change description to “HOSPITALIST MED H”

Bed allocations (3): 6200P1, 6201P1, 6202P1

Virtual pager: 123-7087

MDJ – create new hospital service called “HOSPITALIST MED J”

Bed allocations (3): 6203P1, 6204P1, 6205P1

Virtual pager: 123-7088

MDL – create new hospital service called “HOSPITALIST MED L”

Bed allocations (2): 6206P1, 6207P1

Virtual pager: 123-7089

PATIENT ELOPEMENT POLICY

UNC Health Care has approved a new policy as of 9/18/07 entitled “Patients off the Unit (Including Elopement),” which needs to be carefully reviewed by all staff members. All staff members should be alert to the potential for patient elopement incidents. Below is a list of important elements of our patient elopement policy:

- Inpatients may not leave UNC-Hospitals buildings prior to discharge.
- Inpatients must request permission from his or her nurse or the unit charge nurse in order to leave the unit.
- Patients authorized to leave the unit will be issued an off-unit pass to be visibly displayed.

Patient elopement is defined as:

- Any patient found to have left the unit/procedure area without the knowledge and permission of staff. Contact Hospitals Police (966-3686) and initiate a Code Walker alert.
- Any patient given permission to leave the unit with a green badge who fails to return in one hour. Nursing staff should call the Hospitals Operator (966-4131) and have the patient overhead paged using the patient’s first initial and last name. If the patient does not respond to an overhead page within 15 minutes, contact Hospitals Police and initiate a Code Walker alert.
- Any patient taken from the unit to a procedure area who leaves the procedure area without staff knowledge or permission. Contact Hospitals Police and initiate a Code Walker alert.

In the event that a patient leaves the unit without following the procedures as outlined in the policy noted above, guidelines have been developed to address how staff should respond in the event of an elopement. These guidelines, entitled “Guidelines for Responding to Patient Elopement (Code Walker)” are outlined below:

Guidelines for Responding to Patient Elopement (Code Walker)

If the patient is not located on the unit search, a member of the staff will immediately call the Hospital Police Dispatch Center (966-3686) and request that a “Code Walker” be paged overhead. The staff will give the following information to be included in the page:

1. First initial and last name of the patient
2. Age

3. Race
4. Gender
5. Last location patient was seen

In addition, the staff should let Hospitals Police Dispatch know whether the patient has an order for restraint or a commitment in place.

Any staff member observing a patient leaving the building must:

1. Tactfully approach the patient to determine if they have been discharged.
2. If the patient has not been discharged, staff members should attempt to escort the patient back to the unit.
3. If the patient will not return to the unit, the staff member should contact the Hospital Police Dispatch Center (6-3686) to notify them of the circumstances.
4. Hospital Police will notify the appropriate nursing unit, and the nursing unit will follow up with the patient regarding AMA discharge or other appropriate response or intervention.

In addition to the policy and guidelines referred to above, Environmental Health & Safety (EH&S) has also added Code Walker to the Emergency Preparedness Procedures Quick Reference Guides located on each inpatient unit and in all UNC Health Care departments. The Code Walker protocol should be printed and placed at the back of the Quick Reference Guides if it has not already been added. Should you have any questions regarding the Quick Reference Guide, the Guidelines for Responding to Patient Elopement (Code Walker), or the “Patients off the Unit (Including Elopement)” policy, please contact EH&S at 966-0749.

Resident Training in Documentation and Coding Compliance

With the approval and support of the Graduate Medical Education Committee, the UNC Hospitals Management Information Department and the School of Medicine Compliance Office have completed the third year of a required documentation, coding and compliance training program for residents and subspecialty residents. The initial and second years have proven to be a success as indicated by the positive feedback from participant evaluations. At its May 11 meeting, the GMCEC approved the continuation of the program for all residents and fellows – diagnostic subspecialties excluded. Key aspects of the program appear below.

- The program is intended to enhance the quality of the medical record and patient care. We also believe that the training improves the accuracy and efficiency of hospital and professional fee billing.
- The program has a direct benefit to residents and fellows in preparing for the business side of medical practice that they will face after graduating from their residencies.
- The program consists of two sessions: (1) documentation to support DRG (prospective payment) billing by the hospital and (2) documentation and coding for physician fee-for-service billing.

- Each session is scheduled separately and lasts about 45 minutes. Ideally, there would be about 30 days between each session, but the interval between sessions may be shorter or longer to meet division/departmental needs.
- The UNC Hospitals Medical Information Management Department contacts the residency/fellowship coordinators about scheduling the session on documenting hospital services. This year, instead of the SOM Compliance Office contacting the coordinators for the sessions on documentation and coding to support physician fee-for-service billing, residents are asked to go to our web-based Learning Management System (LMS) for the posting of the course schedule and times for available sessions, where the resident can choose a training session that suits his or her schedule and register at <http://lmsweb.unch.unc.edu>.
- Unlike last year, the criterion has changed this year. Last year, this training was mandatory each year for all residents. This year, it is only for new residents and either those who did not attend last year or those returning residents who attended and wish to attend again. This training is now optional for returning residents.
- The divisions/departments are responsible for providing the space and PowerPoint projectors. Attendance logs will be kept by the instructors and returned to the coordinators for record keeping.
- The attendees complete a form for evaluating the instructors and course content.
- This will, in part, satisfy your systems-based curriculum competency.

The number for the UNC Health Care Compliance Helpline is 800-362-2921.

SECU Family House at UNC Hospitals. Referrals for patients and/or their families-caregivers must be made by a staff person from UNC Hospitals (physician, nurse, social worker, surgery coordinator, chaplain, etc.) by completing a referral form, which can be downloaded from www.secufamilyhouse.org/hospital, then faxed to (919) 918-3830. Patients and their families-caregivers are to be advised that a referral does not guarantee a room, as all rooms are reserved on a wait-list basis. Referrals are accepted up to three months in advance. Each patient/family receives a letter or phone call with instructions prior to their stay. Each family must call the SECU Family House Admissions Office at (919) 932-8000 between 11:00 AM and 4:00 PM on the day they wish to stay to see if a room is available. SECU Family House is located at 123 Old Mason Farm Road, Chapel Hill, 27517; web site www.secufamilyhouse.org; email Janice@secufamilyhouse.org; phone 932-8000; fax 918-3830.

HOSPITAL LOST & FOUND is located at the Motel Unit room 113, phone 6-1241.

SCHEDULING CLINIC APPOINTMENTS

Your clinic appointments are scheduled by our appointment center in the clinic appointment office (6-6000, 6-2511), csgi@med.unc.edu. Please note that if you use this alias found in Global Outlook as "Centralized Scheduling – GI" managed by the School of Medicine, you must have an med email account. Otherwise,

from a hospital account, you must email the central schedulers independent of Outlook at the email address above. You will need to be aware of several points regarding the duties performed by this office:

1. When you plan to be away and need to cancel, reschedule, or make up a clinic, notification should be made at least one month in advance. Please be mindful that it involves considerable work on the part of our appointment center staff for a clinic to be canceled and rescheduled. Your clinic will then be blocked so that patients are not scheduled on that day. This will release your clinic space for use by other physicians. For this reason, Ina Fichtner, clinic nurse manager, ifichtne@unch.unc.edu, 6-9341, needs to know so that she can reassign space to other practitioners who may need it, given our limited clinic space due to our expanding multi-centers. In addition, *you must notify the preceptor of the clinic in question.* This information appears on R You On? Leave should be taken during the research or endoscopy rotation. The fellowship coordinator must also be aware of such leave so that support staff knows to contact the clinic fellow for any urgent patient-related issues. Be sure to cancel any patient add-ons in addition to your clinic. As of 9/04, fellows' clinics are blocked while on a fellow is on luminal consult service. Other than designated vacation (3 sessions) or endoscopy coverage, if a fellow cancels clinic because of an outside conference or a local talk, clinic time must be made up and rescheduled at an alternate date if conference leave is in excess of two clinics. Any unused days do not carry over into the next year. Make-up clinic days will likely be during a time slot when the consult fellow's clinic is blocked. *All new patient medical notes from outside referrals are obtained beforehand and made available to the fellow prior to the appointment.* All doctor-to-doctor referral notes coming into CSGI are reviewed and triaged to the appropriate specialty clinic by five attendings: Drs. Evan Dellon, Lisa Gangarosa, David Ransohoff, Robert Sandler, and Yolanda Scarlett. Special requests to Centers are triaged by Dr. Spencer Dorn (FGID), Laurie Powers (IBD), and Sherin Smetana (Liver). R You On? posts our attending calendar (<https://cgibd.med.unc.edu/ryouon/>). Please direct questions about its use to Fern Jeremiah, fern.jeremiah@med.unc.edu. Separate from R You On, a patient portal has been developed so that physicians can review patient notes prior to clinic encounters. Please contact Joanna Herath, jyherath@med.unc.edu, for issuance of a user name and password. *Please be certain to write the name of the supervising attending at the top of each encounter form, and make sure that the correct attending is indicated.*

Clinic template issues are managed by Shane McCollum, mmccollu@unch.unc.edu. Please note that it entails considerable work for him to switch clinic templates, a rather involved and complex process.

Phones are staffed between 8:00 AM and 4:30 PM daily, but not on weekends or holidays. A line has been assigned to the GI Medicine Clinic (919-843-2638) dedicated for the fellows to give out to patients for them to leave non-urgent messages such as prescription refills and medical questions. This has been designated as the fellows' patient line. Support and ancillary staff members are asked not to page fellows but to email them instead with non-urgent messages because paging can be disruptive if they are doing a case or seeing a patient. When someone from Centralized Scheduling emails you a notice or request to take care of an Rx refill, etc., if you have time and can remember, please let that staff member know once you have taken care of the issue. When there is no return response, emails accumulate in the non-responder queue. Once you respond that something has been taken care of, the ticket is considered remedied and can be removed from the system. As a general rule, we do not include physician pager numbers on our business cards and leave this up to the discretion of

individual physicians if they choose to share their pager number with certain patients, in which case they can indicate their pager number on the back of their business card. Otherwise, patients are asked to call 3-2638 to relay any messages to the fellow physician. Fellows are expected to respond to email/patient calls within 24 hours and to complete clinic notes within 48 hours. Regarding patient no-shows, it is at the discretion of the individual provider whether to see initially or keep in follow up a patient who has canceled repeatedly. Generally a determination is felt to be made upon the third cancellation. Patients are allowed a 30-minute grace period for late arrival to the clinic.

Of note, Central Schedulers do not print out lab results or procedure reports and send to physicians or patients on behalf of the fellow. They answer our phone lines, triage calls to our physicians, and schedule/reschedule appointments. Fellows are responsible for ensuring follow-up communication with physicians and patients. Lab results and clinic visits may be faxed to referring care providers to expedite patient care; otherwise, requests for release of medical information must be faxed to 6-6295.

2. The Appointment Center can call patients individually to cancel/reschedule appointments if a request has been made beforehand within a reasonable amount of time (at least two weeks in advance). If you give them notice of less than two weeks, they will reschedule the patient in the computer system, but you will be responsible for notifying the patient. The GI clinic schedules return patient appointments only at check-out time when a patient is actually there checking out (the physician should note 'RTC' and time frame on the encounter form and ideally accompany the patient to check out to ensure payment); otherwise, return patient appointments are made by our Appointment Center. New patients must be referred by a care practitioner – generally M.D. practitioners, but exceptions can be made – with completion of a referral form faxed, together with the patient's medical records. Upon review of the patient's medical records by one of six attendings, that patient will be scheduled in the appropriate specialty clinic, if indicated. In this way, a patient does not have to make an initial trip, only to learn later that s/he should have been seen in a different specialty clinic, at times by a particular physician with expertise in that specialty.
3. If you need to see a patient on an off clinic day, you can check with Shane McCollum mmccollu@unch.unc.edu to schedule this during your 'hidden' time. 'Hidden' time is additional clinic space reserved for you (at your request) independent of your personal clinic time. Shane is able to unlock this time and schedule within it; general schedulers, however, are not able to do so. When doing this, two things need to be ensured: 1) notify Ina Fichtner, clinic nurse manager (ifichtne@unch.unc.edu, 6-9341), as well as Judy Martin, clinic nurse manager of Medicine clinics (jmartin@unch.unc.edu, 6-9584) of this arrangement in advance so that this will allow clinic staff to make sure encounter forms are at the front desk and that rooms are allocated correctly; and 2) this encounter must be precepted. In particular, if this is a specialty visit such as IBD, an IBD precepting attending needs to be present. It would be best not to add on on Wednesdays, if possible, and avoid Friday AM. In general Monday, Tuesday and Friday afternoons are best times to accommodate a make-up session or an urgent add-on. If you are adding a patient onto the schedule for the same day, please call the clinic staff directly to make sure the appointment is entered into the computer system. Always remember when adding a patient on any off day to check with the appropriate individuals because there may not be a room available for you.
4. If you are ill, let the attending of the service you are on know of your absence so that appropriate coverage plans can be made. If you are sick on a clinic day, please notify our

CSGI as soon as possible so that as many patients as possible can be rescheduled. In some cases, so that last-minute changes are not made, a co-fellow has stepped in to cover for an absent fellow. If such is the case, please be considerate and return the favor. We must be mindful that many patients drive long distances to their clinic appointments here. Also, some must be excused from work, and some who do not or cannot drive must arrange for transportation by van, or sometimes by someone who has to take off from work as well.

5. Consult service: If an inpatient is seen by our consult service and needs to be seen as an outpatient, a return appointment is scheduled. In reviewing clinic notes beforehand, if you feel more time is needed beyond the return slot (e.g., complex case), the master scheduler can convert one new slot into two return ones. When requesting inpatients to be seen in our outpatient clinic post-discharge, before doing so, residents have been asked to confer with the consult fellow to ensure the appropriateness of the referral.

With much prolonged effort, we are pleased to report that our cancellation/no show rate has dropped from 30% to 9%. We attempt to be more accommodating of seeing patients who cannot wait until the next regularly scheduled visit with their provider. Please call directly to the clinic and speak to staff in regard to individual add ons of less than five business days notice to get the appointment date and time. It helps the nursing staff if they have an indication or idea of just how ill – by your estimation or opinion – the patient might be. Please remind patients that they will be given a day and time to come to clinic, but there might be a wait. Clinic staff has also been instructed to be more flexible with placing patients in rooms to improve efficiency and flow. Thus, please check the patient lists to see which room your patient is in. *It is our intention to keep clinics as full as possible.* In the case of late or last-minute appointment cancelations, our CSGI has a back-up list of local patients who are willing to come in so that we can keep clinics as full as possible.

The nursing staff reminds all clinicians that, daily after 5:00 p.m., the staff is on overtime. Because we are trying to decrease and minimize overtime costs, if you are going to be seeing patients beyond 5:00 p.m., you need to notify the staff whether it is necessary for them to stay or not. In addition, staff members of GI surgery – who share space next to us – have complained about our clinics running late in the day if our staff members have already left, leaving them with the obligation of stepping in and covering for us.

All psychologists, social workers, and other ancillary personnel interested in using the two therapy rooms must have templates that do not conflict, perhaps determined by block scheduling. Schedulers cannot assume that these rooms are ‘open at any time’. ‘Do not disturb’ signs are posted to indicate when an ongoing patient visit is in progress, and these signs need to be respected by everyone. Other activities may occur when the room is not in use, and rooms must be cleaned up immediately after use. This pertains to the patient education room as well. If ancillary personnel such as research coordinators are sitting in the patient Ed room without a patient and it is needed for a patient, that individual must relocate. Since patient handouts are located in the patient Ed room, if personnel need information to give to a patient and the ‘do not disturb’ sign is up, please knock, go in quietly, get what you need, and apologize for the interruption. Currently Dr. Weinland has the use of one therapy room on Wednesday PM, Thursday AM & PM, and Friday AM. Donna Evon has the use of one therapy room on Monday AM & PM. As of January 1, 2009, Surgery’s patient Ed room is no longer available. This room remains locked; however, our hepatology patient education continues on Wednesday afternoons only.

Unless a CNA receives special certification, CNAs can no longer review patient medication lists -- only RNs and LPNs can do this. A non-certified CNA can start a medication list review to be then

reviewed again and signed off by a physician, in which case the clinic must take responsibility for the CNA's actions, i.e., the physician who trains and supervises the CNA for this part of their job. Otherwise, if a non-certified CNA triages any patients, the physician must review medications him or herself.

On April 1, 2009, our GI Medicine Clinic became hospital-based, and our Appointment Center staff moved over from UNC to UNC Hospitals. Any and all references to our clinics must use the following title as of 4/1/09: *Gastroenterology Specialty Clinic A service of UNC Hospitals*.

Dr. Spencer Dorn (sdorn@med.unc.edu) has assumed directorship of our GI clinic, in conjunction with Dr. Robert Sandler (rsandler@med.unc.edu), Division Chief, and Joanna Herath (jvherath@med.unc.edu), Division Manager, who serve as consultants.

Of note, the clinic nurse supervisor does not make our UNC nursing policies, so please do not go to her about policy issues. Please direct all issues, complaints, or ideas regarding operations of the clinic to Dr. Dorn.

High-Risk Clinic: Starting September 2010 we have set up a high-risk clinic for patients with inherited GI cancer syndromes. The clinic is multidisciplinary with Dr. Sandler from GI, Drs. Catherine Fine and Jim Evans from Genetics, and Dr. Tim Sadiq from Surgery. Patients can be seen by all members of the team on the same visit to improve efficiency and patient satisfaction. The clinic will serve patients with Familial Polyposis, Lynch Syndrome, Peutz Jeghers, Juvenile Polyposis, Hyperplastic Polyposis, Cowden's, or people with an unusual and at-risk family history. We will arrange for appropriate genetic testing, endoscopic or radiologic procedures and will keep track of continuity of care so that the patient is not lost to follow up.

Initially the clinic will meet once a month on Friday afternoons. Once we increase in volume, we will expand. The clinic will be located in the GI Medicine and Surgery clinic, the home for our other multidisciplinary clinics.

If you are a triaging physician in RYOUON and you run across a patient suitable for the clinic, we will set up a high-risk queue to receive these referrals. If you see patients in procedures or in your clinic who might be appropriate for this clinic, please let Dr. Sandler (rsandler@med.unc.edu) or his assistant, Fern Jeremiah (fern_jeremiah@med.unc.edu), know so that we can get the patient set up.

Latino Clinic: Contact individuals for our newly established Latino Clinic for Spanish-speaking patients include Claudia Rojas, clinic manager, 4162C Bioinformatics Building, 6-5878, cerojas@med.unc.edu; Mayra McCarty, assistant, 4162B BB, 6-5800, mmccarty@med.unc.edu; and Liz Prata, nurse, 4162A BB, 6-0138, prata@med.unc.edu. These three individuals are completely bilingual and work in conjunction with members of our Appointment Center to ensure that Spanish-speaking patients are scheduled in an accurately and timely manner in our clinic and procedure areas.

CLINICAL TRIALS

Paris Davis has organized a bulletin board in the clinic outside the physician's workroom dedicated to ongoing clinical research trials. This should be of great use to clinical trials coordinators and to

physicians in targeting patients for involvement in studies for which they may qualify. Please contact Paris at pea@med.unc.edu, 6-0764, for updates and to coordinate any trials you may want to post. A brief description of active trials should be provided, including inclusion/exclusion criteria. Additionally, there is a bulletin board in the physician's workroom on the right upon entering. This bulletin board is reserved for coding and compliance information and tips and is not to be used for any other purpose. Our exam rooms also contain bulletin boards for patient education-announcement items.

Esophageal

Recently in 5/09 we have begun a study of eosinophilic esophagitis (EoE). The study is examining the diagnosis of EoE, as well as a number of biomarkers, in patients with and without dysphagia who are getting an EGD. Recruitment is primarily at Meadowmont, but may move to Memorial once the study gets fully under way.

We ask your help with taking extra study biopsies during the procedure. This is not dissimilar to a number of other ongoing projects with which you are familiar. For those patients who are enrolled, a research coordinator is present to facilitate the process; however, we want to make sure you are familiar with the protocol:

- 1) Perform the EGD as you usually do. If you decide that biopsies or CLO test are needed for clinical purposes, go ahead and take them as you normally would.
- 2) After your assessment is done, the study biopsies are taken. These include:
 - Four single bite esophageal biopsies from each of 3 locations: distal (3 cm above the GEJ), mid (8 cm above the GEJ), and proximal (13 cm above the GEJ)
 - One set of biopsies from the stomach (one bite from the antrum; one bite from the body)
 - One set of biopsies from the duodenum (two bites from D2)

Please do not hesitate to contact Dr. Evan Dellon at edellon@med.unc.edu with any questions or concerns.

Dr. Shaheen is leading a national study of radiofrequency ablation of Barrett's esophagus. The study uses a device manufactured by Barrx Medical Device to ablate dysplastic Barrett's esophagus and potentially avoid surgery, which carries high morbidity. CEDAS, directed by Dr. Shaheen, has enrolled more patients in this study than any other site. CEDAS welcomes referral of patients with complex swallowing problems, Barrett's, eosinophilic esophagitis, and other diseases of the esophagus.

Endoscopy

Lineberger Comprehensive Cancer Center Solid Tissue Procurement Protocol (LCCC 0905)

The Bone Marrow Transplant Division is currently in the process of establishing a graft-versus-host disease tissue bank to be used for future, correlative laboratory studies. We are requesting assistance from you, our colleagues in the division of gastroenterology, in the procurement of endoscopic, gastrointestinal biopsies for our repository. All patients enrolled in this procurement protocol will already be undergoing a diagnostic endoscopy to establish the presence of active graft-versus-host disease. We are requesting that one additional study biopsy be obtained from each site sampled for diagnostic purposes. For example, if diagnostic biopsies are obtained from the colon and

duodenum, we would request one additional biopsy from the colon and duodenum be obtained for tissue banking purposes. Please refer to the guidelines below for further protocol details.

1. We will notify your scheduler of the patient's participation in the repository study when we set up their endoscopy appointment.
2. Our team will obtain informed consent for participation in the procurement study. You will, therefore, need only document consent for the endoscopy procedure itself.
3. We will fill out an electronic, study-sample requisition form prior to the patient's procedure so that there will be no additional paperwork to fill out on your part. Please process and route the diagnostic biopsies with their usual paperwork per your standard routine.
4. Study biopsies should be placed in your usual specimen containers containing normal saline (not formalin), and kept cold until pick-up (preferably stored on ice). Please place a patient label on each study container, and indicate on the label the site from which the biopsy was taken (i.e. colon, duodenum, etc.).
5. When the study samples are ready for pick-up, please page the tissue procurement facility at 123-2259. They will come to the endoscopy suite to personally pick up the specimens. This activity is limited to Memorial, as the tissue needs to be frozen promptly after acquisition.

We greatly appreciate your assistance with this endeavor. If we can answer any questions, please feel free to contact me, James M. Coghill, M.D., Study Principal Investigator, email: jcoghill@unch.unc.edu, pager: 216-3286.

IBD

At present we are participating with NIH/Johns Hopkins on genetics studies in an attempt to identify genes that may play a role in ulcerative colitis and Crohn's disease. Specifically, we are looking at the African-American population because it looks as though there may be specific genes in this population of patients different from the initial genetic variations seen in the Caucasian population. Any African-American patient with any type of IBD is eligible for participation in this study. They fill out a questionnaire and donate three small tubes of blood. Please keep this in mind when seeing IBD patients. If you know of a potentially interested patient, please page Dolly Walkup at 216-2419.

Additionally, currently there is an active protocol for treating recent flares of ulcerative colitis. The VSL 3 (combination of eight different probiotic bacteria) clinical trial is designed to treat in a blinded, placebo-controlled fashion recent flares or new onset of ulcerative colitis in patients with mild-to-moderate disease who are not taking steroids. The exclusion criteria can be found on Dolly Walkup's website: <http://www.unc.edu/~dwalkup/>. Patients need to have had a flare within four weeks of entering the trial. This is designed primarily for patients who flare through maintenance oral 5-ASA and who would traditionally be candidates for steroid treatment. Many patients would much prefer taking a natural product such as probiotics rather than corticosteroids with their attendant side effects. Please keep this in mind as you see UC patients. If you hear of a recent flare, please resist giving corticosteroids or adding rectal 5-ASA agents, and instead call Dolly Walkup (3-8105; dwalkup@med.unc.edu) for consideration of entry into this study. Your patients will appreciate an alternative to corticosteroids. Dolly is happy to answer any questions you may have and would very much appreciate referrals to this study.

In 1/07, we were approved and initiated a study for patients with Crohn's disease. If you have any Crohn's patients who you wish to start on steroids, please consider this trial. Subjects can never have had Remicade or Humira. This is a tough study to recruit into; therefore, we ask that you try to catch every patient you plan to start on steroids and ask them about participation in this study. Again, contact Dolly Walkup for any questions regarding the logistics of this newly implemented study. Also in 1/07, we are looking to participate in a grant for a UC dysplasia registry. Please email Dr. Isaacs (klisaacs@med.unc.edu) for any patient with UC and dysplasia on biopsy with the following information: age, gender, duration of UC (years), if dysplasia is polypoid or flat (low-grade, high-grade, or indefinite), and outcome (colectomy or continued surveillance). If this project proves feasible, this will give us the opportunity to become involved in a multicenter registry of this patient population so we have a better idea of what happens to these patients.

If you have any patients with ulcerative colitis who are experiencing a flare and who are being set up for a flexible sigmoidoscopy, we have an ongoing observational study whereby the patient donates a few tubes of blood, a stool sample and a single biopsy at the time of the sigmoidoscopy. The flex sig is of no charge to them, and they receive a small payment to help defer the cost of gas. Please contact Dr. Isaacs or Dolly Walkup if you know of someone who fits these criteria.

Currently, 1) if you have any mildly active Crohn's patients who are not on prednisone and who might want to try a nutritional supplement (conjugated linoleic acid), we have an open-label trial involving 12 weeks of treatment. There is evidence this works for inflammation in animals and thus might be a promising approach in patients with Crohn's disease. It is very low risk and can be added to concurrent medications; 2) if you have any pregnant IBD patients, we may want to add them to our registry study; and 3) for refractory patients or patients who have trouble affording biologic therapy, we have a number of promising new biologic agents in trial. Please contact Dr. Isaacs in regard to these three studies.

IBS

Our IBS Group is working on a study looking at the effectiveness of the use of Seroquel, an anti-psychotic medication, in cases of severe IBS. There is a new Takeda study utilizing a pocket PC to record the symptom experience of IBS patients, and an upcoming McNeil study investigating how symptoms and bowel habits change in response to OTC anti-diarrheal medications, such as Immodium. Contact Ashley Messina, ashley_messina@med.unc.edu; Katie Baillie, kbaille@med.unc.edu; or Dr. Stephan Weinland, stephan_weinland@med.unc.edu, for more information.

Three current projects include the Narcotic Bowel Syndrome (NBS) study, IBS Partner study, and Digital-Rectal Exam study. The aim of the NBS study is to assess patients in terms of underlying diseases, clinical features, medications, psychiatric co-morbidity, and treatment response. The IBS Partner study seeks to evaluate the affect of IBS on partners of patients, and physician and medical student views are gauged utilizing the Digital-Rectal Exam. Contact Hollie Edwards, hollie_edwards@med.unc.edu, or Dr. Joseph Zimmerman, Zimmererj@yahoo.com, for more information.

Genetic and environmental factors that cause or influence IBS: This study involves measuring the relationship between genes, the environment, and various psychological and health factors in men and women with IBS. Individuals who participate spend one overnight visit in the Clinical and Translational Research Center at UNC Hospitals, with no additional visits required. Contact Lenore Keck, akeck@med.unc.edu, for more information.

Characterization of IBS symptom episodes: The purpose of this study is to learn about the natural history of IBS, or how it changes from day to day with respect to bowel symptoms, pain and bloating. Patients keep track of their IBS symptoms every day for 90 days by logging into a secure website. All responses are anonymous and confidential. No visits to UNC are required. Contact Marsha Turner, mturn@med.unc.edu, for more information.

Role of mitochondria in IBS: The purpose of this research study is to learn about the role mitochondria can play in IBS. The study involves one phone interview, completion of one questionnaire, and a saliva sample for analysis. No visits to UNC are required. Contact Miranda van Tilburg at Tilburg@med.unc.edu for more information.

Additional studies include: a) *treatment of fecal incontinence* and b) *lubiprostone effects on visceral pain sensitivity*, jane_tucker@med.unc.edu; *writing and IBS*, Alben Halpert at Boston University School of Medicine – see www.bmc.org/ibs; and *mindfulness for women with IBS*, becky_coble@med.unc.edu. Kim Meyer is recruiting a) men and women with IBS, b) men and women with constipation-predominant IBS, and c) men and women with diarrhea-predominant IBS (kimmey@med.unc.edu). Jane Hankins is recruiting men and women between the ages of 18-70 with diarrhea-predominant IBS and overweight (hankins@med.unc.edu).

Cardiopulmonary Resuscitation Policy:

The Cardiopulmonary Resuscitation Policy (C-9) states that the Code Blue Team will respond to emergency pages within UNC Hospitals and to an area within approximately 25 feet from the entrances to the Emergency Department, Children's Hospital, Gravelly Building, Memorial Hospital, Neurosciences Hospital, and Women's Hospital. Surrounding areas include any area beyond approximately 25 feet from the above entrances, including parking lots and decks, the Dental School, the Beach Café, University Student Health Services, and the Motel Unit. The Code Blue Team does not respond to areas surrounding UNC Hospitals because of concerns about the ability of the Code Blue Team to respond in a timely manner, concerns about the ability to rapidly deliver necessary resuscitation and transportation equipment, and concerns about the impact on existing patient care responsibilities if staff were to respond to emergency pages for areas surrounding UNC Hospitals. If there is a cardiopulmonary arrest in areas surrounding UNC Hospitals, 911 should be called to respond to the emergency.

The full text of policy C-9 is located at <http://intranet.UNCHealthcare.org/site/site/w3/policies>. Please call 6-3043 for any questions or comments.

RADIATION SAFETY TEST, WEEKLY RADIOLOGY CONFERENCE, RADIOLOGY SERVICES

Per Dr. Ian Grimm, Director of our GI Procedures Unit, all fellows need to complete the radiation safety on line training and take the test to use our fluoroscopic equipment. At some point during

the clinical component of our program, all fellows use this equipment as part of placing motility catheters during clinic fellow months as well as any biliary work or dilation work. The web address is http://ehs.unc.edu/training/self_study/fluoroscopic/index.htm. Additionally, fellows are encouraged to meet with Dr. Grimm formally to be trained on how to operate this equipment.

All fellows are welcome to attend the Radiology Conference held each week day from 12:00 p.m. to 1:00 p.m. in the radiology conference room in the basement of the Women's Hospital. In particular, the Wednesday PM conference is recommended for GI physicians.

RADIOLOGY SERVICES: For all Medicare patients who need to be scheduled for radiology services, the front staff has to perform a check for Medicare Medical Necessity in the GE system prior to scheduling. If the procedure is not covered by Medicare, the system alerts staff that the service will not be covered, in which case the patient has to sign a form (ABN), indicating that they will pay for the service if Medicare does not. Please advise Susan Owen of any frequent radiology tests ordered for patients so that a compendium of diagnosis and procedure codes can be used in order to do the checks.

Systems Access for Clinicians

All physicians need level 3 services for access and use of WebCIS. Clinicians also need access to Impax Digital Imaging, PACS for Web, and E-chart programs. Instruction for PACS (Web) can be done on line. For Siemens CPOE, a two-hour training course is required before a physician can be granted permission to use this system. The physician needs to contact Craig Brown, training instructor, at CBrown@unch.unc.edu, who can let the physician know of course availability and how to register on line through the Learning Management System (LMS).

For access and use of Transchart, a program that stores information on transplant candidates, the physician needs to contact Lauren Kerns, RN, of our Transplant Program, at 6-1633 (fax 3-0860) or LKerns@unch.unc.edu.

For access and use of our ProVation system for procedures, please contact Jennifer Timmons, RN, of our GI Procedures Unit.

HIV Testing Consent Form

All patients must consent to having an HIV test performed. In an effort to make the process of HIV testing more comfortable for everyone and, in particular, because of patient confidentiality, we have provided an HIV testing consent form (now blue) in the GI Medicine lab folder in every exam room. The care provider will need to fill out the top section of the form by writing the name and medical record number of the patient, sign the form, and then have the patient sign the form. It will then be given to the patient – along with the check-out papers – for the front staff to check the patient out (ideally the care provider should make every attempt to accompany the patient to check out to make sure this process is carried out). *Please go over this carefully with the patients to make sure they are willing to have this done.* There have been some instances of patients not handing consent over at lab, either because of misunderstanding or not really wanting the test done. Staff has been asked to staple the blue consent form to the printed order form.

CLINIC GUIDELINES TO FOLLOW:

1. All physicians need to be on time, including preceptors. “Do not call from home and know you have an 8 am patient and then arrive at 8:30 am.” If your schedule shows a patient in the 8:00 a.m. slot, be on site at 8:00 a.m. Staff should not need to, nor do they have time, to call while patients are checking in. A patient who is on time should not have to wait. Bring something to work on in the event you are on time and the patient is late. Regarding inclement weather, unless roads are impassable, attendings, fellows and nurses need to be in clinic; in particular, attendings need to be in clinic at the start of their templates. No one can predict which patients will show up and which ones will not due to inclement weather. Clinic hours of operation are from 8 a.m. to 5 p.m. Do not tell or let any ancillary help tell patients to come at 7:00 a.m. Limited staff present and the ones there at that time have other duties to attend to before starting check-in procedures.
2. Try to make sure that all pertinent information is entered correctly so that check in will run smoothly.
3. Do not overbook clinics unless there is physician approval. For example, if a physician indicates on an encounter form ‘RTC in 3 wks’ and all slots are booked, the CBA is *not* to overbook within that time unless approved by the physician.
4. Follow the templates.
5. Handwriting needs to be legible on encounter forms and lab slips. Staff should be able to easily read MD codes so they do not have to look these up repeatedly. This code is required for physician order entry. If you find that labs you thought you ordered did not get done, please let staff at the front desk know.
6. Remember to wear your hospital ID badge at all times in the GI Medicine Clinic.
7. Please be aware that each individual has certain job responsibilities. Staff cannot attend to everything simultaneously. Staff cannot be asked to do duties outside of their purview and should not have to hear complaints because it inconveniences you. The clerical staff cannot code. If the diagnosis needed for a visit is not on the encounter form, the fellow and attending need to provide both a diagnosis and ICD-9 code, which they must look up and note on the form, after which Joanna Herath (jvherath@med.unc.edu) must be notified so this information can be added to our electronic encounter form. Our forms are in the process of being updated. Encounter forms must accompany the patient to check out. There have been cases where physicians have turned in encounter forms a week later – this is not acceptable because we collect monies at check out. Additionally, make sure all encounter forms have a proper diagnosis and CPT code checked. If this is not done correctly, the physician will be called to the desk. All encounter forms must be filled out appropriately in order for the CBA to check the patient out. The actual code must be on the form – please do not write in the diagnosis or the procedure without the corresponding codes. The CBA’s can take verbal instructions on which CPT and diagnosis codes to check; however, they cannot code themselves. If there is more than one diagnosis, please note # 1 or # 2 to let the CBA know which diagnosis is primary. This makes a big difference on whether the claim is paid or not. Putting in the secondary diagnosis first will cause the claim to deny. If the codes are left off of the form, we cannot check the patient out. Patients cannot leave until we have collected their co-pay and/or co-insurance or directed them to our financial counselor to establish a payment plan. Please do not bring encounter forms up to the front desk and leave them there. The main check-out is at the nurse’s station, and there is a sign reflecting this. Also, by bringing the encounter form up without the patient being present, the CBA does not know who the patient is, and, many times, these patients do not stop at check-out, in which case no payment has been made or payment plan arranged. If you bring the encounter form up to check-out, please have the patient with you so that co-

- pays and co-insurance can be collected. Encounter forms must be signed at the bottom so we know who actually filled out the form.
8. Should problems arise, speak with the clinic nurse supervisor first. Give constructive criticism to the appropriate people at the appropriate time. Respect and treat with courtesy all ancillary staff. If you have a problem with a clinic staff member, you should discuss it with that individual privately and confidentially or bring it to the attention of Joanna Herath. Please do not criticize staff in front of other staff members or patients.
 9. Remember items that have PHI cannot go into the regular trash bin and must be put in the Shred-It bin. Of note, unused lab slips are frequently found in exam room trash bins—these must go in our confidential Shred-It bins. Exit out of WebCIS at the end of each patient encounter so that the next patient cannot see the results or PHI of the previous patient and limit patient care-related conversations in the hallway. Please maintain our physician workroom responsibly and check your mailbox in the workroom at least once a week. Upkeep of the physician workroom is the responsibility of the providers there each day, not the clerical and nursing staff. X-rays sitting on shelves need to be disbursed of appropriately and not left lying around. Regarding outside films, either give them back to the patient to return after your review or send them to our radiologists for formal review. Numerous times the clinic director has encountered a “mess” in the chart area, personally having to go through a pile of outside records and dividing what goes to medical records from CIS printouts needing to be shredded, in addition to stacks of paper on the counter behind the entry door and messy countertops. Old charts need to be put in the box labeled for medical record pickup. As in GI Procedures, routine delivery of charts has been discontinued since most information is now on CIS. Old charts may have to be requested for esophageal and anorectal clinics because several procedures for them are still not available on CIS including rectal manometry, esophageal manometry, and 24-hour PH probe study. Medical records assures that if a chart is needed, it can be called for and arrive within an hour.
 10. Treat GI problems and not continuity of patient care for things like back pain, nose bleeds, and asthma. We are a specialty area, supposedly to see and possibly manage complex issues of GI that primary physicians may not have expertise in. If such patients do not present with a primary MD, refer them to General Medicine where they can be assigned one.
 11. Return patient phone calls within 24 hours.
 12. Educate patients about appropriate expectations. Please tell them that they will only be called with lab results if there is an abnormality requiring attention.
 13. Only take emergency phone calls during clinic hours. All other calls coming into the GI fellows’ patient line (843-2638) are checked and triaged by the fellowship program coordinator. The clinic nurse does not call in prescriptions: the appropriate attending or fellow or clinic fellow in their absence is responsible for doing this.
 14. Please be flexible in dealing with room assignments. If you do not like a room assignment, talk to a physician in another room who is willing to switch. Do not bother nursing staff over minor issues such as this. Remember that each provider has a finite number of rooms assigned to him/her. You may therefore have patients checked in and in the waiting room, but if your room is not available, they will remain in the waiting room.
 15. Please be diligent in getting holiday time to the schedulers. This should be around the beginning of November.
 16. You are welcome to preview records received on patients scheduled with you.
 17. If you print prescriptions from WebCIS, please tell patients what it is because they are not used to prescriptions in such a format.

18. Patients who have questions about their bill should be referred to Patient Accounts: for UNC P & A, they can call 919-966-2211; for UNC-Hospitals charges, they can call 919-966-1234. If they have a question about CPT and/or diagnosis codes, you can refer them to our coding specialist, Tina Blanton, tina_blanton@unchealthcare.org, pager 216-8107, phone 6-0404.
19. Per the Assistant Attorney General, we cannot deny services to a patient who owes us money or whom we are suing for back payments. A physician must always provide necessary medical services.
20. If a patient needs to make arrangements with a financial counselor, s/he may contact Ms. Tina Blackmon at 966-7239 (tina_blackmon@unchealthcare.org). Her office is located on the third floor of the Ambulatory Care Center (ACC). If this information is not correct, please email Linda Raftery at linda_raftery@unchealthcare.org (phone 6-3801, fax 6-7005). The number for patient relations is 6-5006. This is the number you also call if you must interact with deaf patients.

Infliximab Infusions: Infliximab infusions are increasing. At this time we do not have the services of a part-time R.N. to help with these; therefore, our nurse manager is trying to manage all of these, leaving her staff to manage triage. We are considering the possibility of hiring an agency nursing assistant to help with triage and infusions. In the meantime, please have patience.

LVPs: Time slots for LVPs are 11:00 AM or 1:30 PM every day running on time at one procedure per day. Schedule LVPs through Ina Fichtner (6-9431).

REMINDER: When you perform and charge for an LVP in clinic, you must let Tina Blanton, our coder, know of this so that the same procedure is not billed twice, once in clinic and once in procedures, as has been the case on several occasions. You must therefore indicate in the note that the LVP was done in clinic. If the LVP is subsequent to another procedure on the same day, the LVP is coded as 49081. Otherwise, each time the patient comes back for an LVP only, the initial LVP code of 49080 is used (the higher coded value).

Please be careful about the documentation and billing for LVP's performed in clinic. If you are not doing a separate E & M, do not check one of those codes off. If you are doing a separate E & M, make sure there is a dictation for it. Do a separate dictation for the LVP. If you are using ProVation to document an LVP in clinic, make sure Tina knows so it is not billed for twice. Make sure you know who the attending is, and hepatology attendings in particular may want to look over the billing sheet before it is turned in. If you have questions about coding issues, please do not guess – ask.

In addition, any bedside procedures you may perform in addition to LVP's, such as a thorocentesis, Tina should be given a copy of the operative note since, because we no longer have MDA, she no longer has charts assigned to her, and the coders for MDA and MDW-MDU services may not code for these procedures. There have been such instances in which procedures were overlooked in this way and not billed, or billed later if Tina happened to come across documentation. Thus, to ensure that these procedures get coded and billed, please make sure Tina gets a copy of the report, for, “if she does not see it, then it cannot get billed.”

R2D2 for LVP's: For patients needing LVP's, often there is loculation, or, if fluid does not return with the initial stick, the patient has to be sent to U/S for marking, then has to come back so that the procedure can be reattempted. The portable R2D2 kept in our GI Procedures Unit can be used in clinic for this purpose, as well as in GIP, the Clinical Trials Research Center (CTRC), and up on

the floors for liver biopsies. This not only helps with time management, but also reduces complications. Radiology performs maintenance and certification on the unit. Fellows are welcome to use it in clinic for fluid searches as long as they return it for storage in GIP. Complications should be reported to Dr. Michael Fried, mfried@med.unc.edu.

PEG's: Please note that PEG tube removals can be done in clinic and do not need to be done in the endoscopy unit unless there are extenuating circumstances. PEG tube removal is not considered a procedure: there is no CPT billing code for a simple removal. Instead, this gets billed as an 'established patient clinic visit'. This is NOT true for PEG tube exchange, however, which does have its own billing code. Again, resources of the endoscopy unit do not need to be used for this purpose.

For calls regarding the removal of a PEG on an unassigned outpatient on whom we have placed a PEG, please follow this protocol:

1. Direct the call to the clinic (ambulatory) fellow (pager 123-7044);
2. The clinic fellow should arrange for the patient to come to the clinic to have the PEG removed. This visit should generally take only about 5 minutes or less.
3. Since PEG removal is done in clinic, it gets dictated as a clinic note, which can be brief.
4. The attending in clinic can staff this.

Ostomies: Medicaid does not reimburse UNC Pharmacy or any pharmacy for ostomy supplies (although private health care insurance carriers do reimburse for such supplies). However, there has been a slight change—Medicaid now pays for ostomy supplies if they are home delivered to individuals being cared for by home health nurses. This requires a social work consultation to process the necessary paperwork. If you have a patient with an ostomy, they are covered by Medicaid, and they get their supplies here, please call or email Anthea Darling, RN (AntheaLD@med.unc.edu, 3-8107), who may be able to facilitate your patient's enrollment in a home health delivery program. Home Health is able to establish a "supply only" visit for ostomies, for which patients who are not homebound are eligible as well. If a fellow needs to contact the hospital ostomy consult service, that pager number is 123-2156 or 123-2157.

Ancillary Clinical Resources

The American Medical Association (AMA), www.ama-assn.org, contains a 'for patients' corner on its site, which includes a patient network, 'your doctor' and 'doctor finder', 'share your story', patient education resources, bookstore, specialty & state societies, and a section for parents.

Clinician publishes medical data arising out of scientific meetings or submitted as papers forming the theme of a monograph on contemporary therapeutics. Information concerning this publication can be directed to: The Editor, *Clinician*, IMED Communications, 518 Route 513, Dept. 102, Suite 200, PO Box 458, Califon, NJ 07830. Other journals of potential benefit include *The American Journal of Managed Care*, www.ajmc.com; *Mayo Clinic Proceedings*, www.mayoclinicproceedings.com; *North Carolina Medical Journal*, www.ncmedicaljournal.com; and *M.D. News* (a business and lifestyle magazine for physicians in the Research Triangle area), email MDTriangle@triad.rr.com, www.mdnewsonline.com. Centra Health publishes a newsletter (formerly *News Digest*) called *Mental Health Matters*, www.centrahealth.com. There is also the newly formed site www.BariatricEdge.com. *Hospital Physician* is a publication dealing with medical practice for staff and residents, www.turner-white.com. *Holistic Primary Care* contains news for health and healing, www.holisticprimarycare.net.

For the latest news and other online features, visit www.GastroHep.com, the global resource for gastroenterology, hepatology and endoscopy. Also, www.blackwellgastroenterology.com provides access to numerous GI-related journals, including *Alcoholism*, *Alimentary Pharmacology & Therapeutics*, *The American Journal of Gastroenterology*, *American Journal of Transplantation*, *Colorectal Disease*, *Digestive Endoscopy*, *Diseases of the Esophagus*, *Helicobacter*, *Hepatology Research*, *Journal of Digestive Diseases*, *Journal of Gastroenterology and Hepatology*, *Journal of Viral Hepatitis*, *Liver International*, *Neurogastroenterology & Motility*, and *Transplant International*. *Hepatology Research* is the official journal of the Japan Society of Hepatology; *Liver International* is the official journal of the International Association for the Study of the Liver.

Achieving Competence Today (ACT) is a web-based curriculum to identify problems in quality and use of system-based approaches to improved patient care, www.actcurriculum.org.

An online resource providing hospital quality of care information, www.HospitalCompare.hhs.gov, provides the public with useful and understandable information in an easily accessible way to assist patients, families and communities in making important health care decisions.

“Hand Hygiene in Health Care Settings” can be found at the Center for Disease Control (CDC) site, www.cdc.gov/od/oc/media. This site contains health topics from A-Z, including anthrax/bioterrorism/SARS, colorectal cancer screening, diarrhea, E. coli, E. histolytica, EBV, HIV/AIDS, H. pylori, genomics and disease prevention, hemochromatosis, iron overload, viral hepatitis, Lyme disease, mad cow disease, nutrition, obesity, and parasitic infections such as hookworm, pinworm, tapeworm, ringworm, Rotavirus, Salmonella, Schistosomiasis, trichinosis, and Yersinia.

Adverse weather. The hospital sponsors a ‘snow desk’ (6-2393), but only during inclement weather. Weather updates can be provided in a ‘listen only’ format by calling 3-9785. Clinic patients may call 3-1414 (919-843-1414).

The Department of Public Safety does not determine the university’s adverse condition; the Chancellor’s Office makes those decisions. The Department of Public Safety (Parking), does, however, determine the status of parking on campus. In the event of inclement weather, employees have the following options:

1. University operating status: call the toll-free number 685-8100 to receive recorded information.
2. The university’s home page <http://www.unc.edu> contains a link to the Department of Public Safety’s home page <http://www.dps.unc.edu>, where information is posted in regard to campus parking and transit information. The Department of Public Safety’s parking information line is (919) 558-5960 or 5961. The Department of Public Safety’s main phone lines are 2-3951 and 2-3952.
3. Tune to the following radio stations: WUNC (91.5 FM), the university’s radio station; WCHL (1360 AM), a local radio station serving the Chapel Hill area; WNDW (1610 AM), the university’s low frequency travel advisory radio.
4. Visit the town of Chapel Hill’s website at <http://www.ci.chapel-hill.nc.us> or call Chapel Hill Transit Authority at 968-2769.

For information on hurricanes and other potentially harmful natural occurrences, please contact the North Carolina Department of Crime Control and Public Safety Emergency Management Division at 919-733-3867, www.nccrimecontrol.org. Carolina Poison Center’s number is 1-800-848-6946.

The North Carolina Statewide Program for Infection Control and Epidemiology (SPICE), Division of Infectious Diseases, has created a web site to include information about bioterrorism, www.unc.edu/depts/spice/bioterrorism.html. **Alert Carolina!** notifies the campus community about life-threatening and serious emergencies through various means, including text messages sent to registered cell phones. At <http://alertcarolina.unc.edu>, you can register or update your text-capable cell phone number, which will not be published and is strictly for emergency use.

CLINIC FELLOW RESPONSIBILITIES

GOALS and EXPECTATIONS:

1. To gain advanced clinical experience in management of patients with liver disease who are or may be transplant candidates, patients with inflammatory bowel disease, patients with biliary disease, patients with pancreatic disease, patients with esophageal disease, patients with functional bowel disease and motility disorders, and patients with viral hepatitis under the preceptorship of faculty members with special expertise in those areas.
2. To see up to five new patients per week who need to be seen in a GI clinic on an urgent or semi-emergent basis. For open sessions, fellows may see follow ups or add ons. This is also a good time to schedule and perform outpatient endoscopy procedures, provided that this does not detract from cases for endoscopy fellows. Time during open slot availability is to be used wisely and productively (such as dictation and review of clinic notes).
3. The clinic fellow is the back up to take calls if the consult attending cannot be reached. The consult attending takes all calls from outside physicians and UNC clinic physicians for urgent and semi-emergent GI problems.
4. The clinic fellow may see patients of GI attendings who receive calls to see new or established patients on an urgent or semi-urgent basis and cannot do so because of commitments or absence.
5. To answer urgent requests from the patients of the GI faculty and fellows, in their absence. If a fellow switches with another clinic fellow, the fellowship coordinator and support staff need to be made aware of this change.
6. On rare occasions to assist with inpatient consults, if needed.
7. The clinic fellow is the primary coordinator for our weekly clinical case conference held each Tuesday in the OR classroom on the second floor of the main hospital from 4:30 – 5:30 PM.
8. The clinic fellow should arrive ahead of time to set up the computer for our weekly pathophysiology (core curriculum) conference held each Thursday from 7:30 – 8:30 AM in 4137 Bioinformatics.
9. The clinic fellow should always stay around until the end of the session, unless expressly let go by the preceptor. Often times, even after scheduled patients are done, there is a return or two that the clinic fellow can assist with. Of note, this includes, in particular, our Wednesday PM FGID Clinic.

10. In the event the schedule is arranged such that there are 2 clinic fellows, Clinic fellow 1 (A) serves as the initial point person who triages messages and delegates to clinic fellow 2 (B), and each can serve as the back up to the other.
11. Clinic fellows are expected to orient, guide and instruct 3rd- and 4th-year medical students doing outpatient rotation work in our GI clinic.
12. Please make sure your outpatient clinic notes are dictated within 24 hours, and signed promptly. Attendings have been instructed that all notes need to be signed no later than 7 days from the date of service, including notes originated by fellows. We would prefer that you not be the deterrent step in this process. Additionally, please review manner of expression and accuracy of content before signing off on your portion of the note.
13. Sign ambulatory pager over to next clinic fellow.

A. Specialty Clinics. These patients will be scheduled for you and do not require any scheduling action on your part. Clinic times include 8:00 – 12:00 AM and 12:15 – 4:15 PM.

1. See two new patients each Monday morning in the Liver General and Transplant Clinic. In most cases the fellow will not follow transplant patients because the liver transplant faculty will do this. During their liver clinic rotation, fellows are encouraged to see any new patients who are not transplant patients, e.g., NASH, to be followed up by the fellow, if possible, to gain additional experience in this subfield. Fellows are encouraged to talk with Dr. Zacks about this opportunity. Dr. Zacks does not start his clinic until 9:00 AM. Fellows tend to show up at that time because he is the designated preceptor for that clinic experience. To maximize clinical involvement for this rotation, Dr. Hayashi has asked that the clinic fellow show up at 8:00 AM instead to see patients with him, as his clinic begins at that time.
2. See two new patients each Monday afternoon in the Esophageal Clinic. In most cases follow up will be provided by the fellow, but this will be discussed on a case-by-case basis with Dr. Shaheen.
3. See two new patients in the Inflammatory Bowel Disease Clinic on Tuesday mornings. Follow up of these patients generally will be done by the clinic fellow in his/her continuity of care clinic or as decided otherwise by the IBD clinic attending/Dr. Isaacs.
4. See two new patients in the Motility Clinic on Tuesday afternoons. In most cases follow up will be provided by the fellow, but this will be discussed on a case-by-case basis with Dr. Scarlett.
5. See two new patients in the Hepatitis Clinic on Wednesday mornings. In most cases follow up will be provided by the fellow, but this will be discussed on a case-by-case basis with Dr. Fried.
6. See two new patients Wednesday afternoons in the Functional GI Disorders (FGID) Clinic. Patients will be followed by the fellow in most cases; however, this will be discussed on a case-by-case basis with Drs. Drossman and Ringel.

7. See two new patients each Thursday afternoon in the Liver Transplant Clinic. In most cases the fellow will not follow transplant patients because the liver transplant faculty will do this.
8. See at least three new patients and four returns each week in your continuity of care clinic. Clinics held on Thursday AM are precepted primarily by Dr. Nuzum, in addition to various volunteer attendings. Clinics held on Friday PM are precepted by Dr. Orlando.

If, as in the past, there is an increase in clinical fellows, this rotation is divided up into Clinic A and Clinic B. Fellows rotating through Clinic B also have the opportunity of seeing two new patients in the Pancreaticobiliary Clinic scheduled for Thursday PM. Patient follow up will be provided by Dr. Grimm or in the fellow's clinic, as decided by Dr. Grimm on a case-by-case basis. The fellow rotating through Clinic A is designated as the 'Clinic Captain', responsible for delegating or triaging clinic issues to fellow B and/or to the appropriate ancillary staff member.

First-year research fellows are expected to perform minimal clinical work in any two of our four specialty clinics: Esophageal, FGID, Hepatitis-Transplant, IBD, one specialty for each semester. These clinics are assigned in part based on the fellow's career path (if decided upon). These fellows will then have a personal clinic for the next three years. Fellows are expected to work two years with the general GI caseload and subsequently can have a specialty clinic such as IBD or liver during their last year. In this case, new patients within that specialty are scheduled into the fellow's clinic thenceforth, but the fellow keeps his or her return patient caseload. First-year research fellows with liver clinic may want to apportion time such that 1st and 3rd weeks are hepatitis and 2nd and 4th weeks are transplant (as an example) to broaden exposure.

Third-year clinical fellows may choose to work in the Pancreaticobiliary (PB) Clinic on Thursday PM in tandem with Dr. Grimm's clinic, contingent upon volume and need. This must be agreed upon by Drs. Grimm, Madanick (Program Director), and Sandler (Division Chief and Clinic Director). Again, in this case new PB patients are scheduled into the fellow's clinic thenceforth, but the fellow keeps his or her return patient caseload.

B. Urgent and Semi-Emergent Patients. The clinic fellow may see up to an additional five new patients each week. These patients may be scheduled only by or on approval of an attending physician and that attending **must** precept the clinic fellow when the patient is seen or arrange for another attending to precept. The attending physician can personally schedule the patient with the clinic appointment center or have the clinic fellow do it, but the appointment must be at a time when both the fellow **and the attending** or a substitute attending can be present. Ina Fichtner, nurse manager, must be notified ahead of time to ensure adequate clinic space, since space is limited. Additionally, fellows may have designated 'hidden time' within their templates where such patients can be scheduled – including patients seen on 'off days' (add ons). This is time that other schedulers cannot see but that the lead scheduler can go into, release, and schedule patients into.

1. The **consult attending** takes all calls from outside physicians and UNC clinic physicians for urgent and semi-emergent GI problems. The clinic fellow is the back up to take these calls if the consult attending cannot be reached. At the discretion of the person taking the call, patients can be scheduled to be seen by the clinic fellow or in a faculty clinic, depending on the urgency. Any follow up required by the patients seen by the fellow will be done in the fellow's own continuity of care clinic, precepted by the fellow's clinic attending, unless otherwise decided by the attending who schedules and precepts the initial work up.

2. Other GI attendings who receive calls to see new patients or established patients on an urgent or semi-emergent basis and cannot do so because of other commitments may also arrange with the clinic fellow to see a patient, but the attending **must** precept the patient or arrange for another attending to do so. Any follow up required by these patients will be provided by the patient's attending or fellow physician unless that physician continues to be out of town when follow up is required, in which case it will be done in the clinic fellow's clinic and precepted by the fellow's clinic attending.
3. Support staff who receive calls from patients requiring the attention of a physician but whose GI attending or fellow is out of town will ask the clinic fellow to respond. If the patient requires an urgent or semi-emergent clinic visit, the consult attending must be contacted by the clinic fellow to arrange a time for the clinic visit when the consult attending can precept. Any follow up required for these patients will be provided by the patient's attending or fellow physician unless that physician continues to be out of town when follow up is required, in which case it will be done in the clinic fellow's clinic and precepted by the fellow's clinic attending.

C. Motility Services.

The UNC Hospitals Motility Laboratory provides diagnostic motility testing for adult and pediatric patients. Routine diagnostic studies offered include 24-hour pH probe testing, esophageal manometry, anorectal manometry, hydrogen breath testing, C-13 breath testing, and small bowel motility testing.

While on the motility service fellows are expected to become familiar with performing each study and proficient in study interpretation. Fellows should also observe pelvic floor retraining sessions. Fellows should become knowledgeable with common ancillary tests such as transanal ultrasound and defecography. In addition, at the completion of the rotation, fellows should be competent in providing consultation services for patients with motility disorders.

Anorectal clinic is held each Tuesday PM. Conferences specific to the manometry rotation include Motility Lab working rounds Monday at 8:30 a.m. in Room B0007 located in the basement of the main hospital. Anorectal Conference is held the third Wednesday of each month at 7:30 a.m. in room 4002 of the Old Clinic Building (Urogynecology Conference Room). The fellow should plan to present one case at the anorectal conference. Reference articles and texts are available in the motility lab.

Esophageal clinic is held each Monday PM. When fellows are learning to read pH-impedance studies with Dr. Madanick, they should review a video online on Sandhill's website to understand how to use the software for interpreting the tracings.

First, they need to go to <http://www.sandhillsci.com/index.php?activePage=clined&page=go-to-login> and request a login (click on "Request A Login" at bottom of the page). Once they have their login ID, they can login and watch **4. Editing Tools and Techniques Impedance V5 (#6511)** (it's #9 on the list...)

They can also look at other videos there, but most of them are geared toward the technician or nurse who acquires the study. Unfortunately, anorectal tutorials are not yet available. Generally Friday is the day in which Drs. Scarlett and Madanick are reading results (ad hoc) in the motility lab.

D. Psychosocial Assessment/Treatment Referrals

The GI division has access to two clinical psychologists who work towards assessing and treating psychosocial contributions of a patient's GI illness. Dr. Cara O'Connell-Edwards (coconnel@med.unc.edu) is a clinical psychologist who works with the FGID clinic. Dr. Donna Evon (donna_evon@med.unc.edu) is a clinical psychologist who works with the hepatitis clinic. As these clinicians are not medical doctors, all patients referred to them for treatment should have completed a biomedical evaluation prior to referral. Specific referral questions are always preferred, and a psychosocial assessment will be completed at the patient's first visit with the psychologist. Please contact Drs. O'Connell-Edwards and Evon regarding any potential patient referrals to them. If a referral is accepted, confirmation is forwarded to our appointment center staff, who will schedule the patient into the next available appointment. Dr. Evon sees patients on Monday mornings and afternoons. Dr. O'Connell-Edwards sees patients on Wednesday mornings and afternoons. Additionally, please contact our psychologists to discuss possible inpatient psychosocial evaluations and treatment.

PATIENT CASELOAD TRANSFERS

Patients formerly belonging to Dr. Kimberly Beavers go to Dr. Jeffrey Wei > Sid Barritt, Dr. Craig Cender to Dr. Julia Tsang > Jonathan Hansen, and Dr. David Weinstein to Dr. Evan Dellon. Patients formerly belonging to Dr. Jason Conway go to Dr. Joseph Cassara. Patients formerly belonging to Dr. Sanjib Mohanty go to Dr. Greg Austin. Patients formerly belonging to Dr. Ritesh Shah go to Dr. Shannon Vish, Dr. Ryan Wanamaker to Dr. Spencer Dorn, and Dr. Howard Zhang to Dr. Syed Thiwan. Dr. David Grunkemeier keeps his existing caseload for 2006-2007.

For the year 2007-2008, Dr. Grunkemeier's IBD caseload is referred to the IBD Center (sfwoody@med.unc.edu, 6-0140) and liver caseload to our Liver Program (sharron_jones@med.unc.edu, 3-9483). His general GI caseload – in addition to Alex Kim's – is routed to the following fellows: patients with last names A – F go to Dr. Spencer Dorn; patients with last names G – L go to Dr. Sid Barritt; patients with last names M – S go to Dr. Jon Hansen; patient with last names T – Z go to Dr. Shannon Vish. Millie Long will be taking over Dr. Greg Austin's caseload in mid-August once she returns from maternity leave. Dr. Evan Dellon will remain in our program for an additional year and thus keep his current caseload.

For the year 2008-2009, Dr. Joe Cassara's patients with the last names beginning A-M can be transferred to Dr. C. Brock Miller; those whose last names beginning N-Z can be transferred to Dr. David Frantz. Dr. Syed Thiwan's caseload can be transferred to Dr. Farzad Nowrouzadeh.

For the year 2009-2010, Dr. Shannon Vish's patients whose last names are from A – M can go to Dr. Eric Orman; patients whose last names are from N – Z can go to Dr. Laurie-Anne Swaby. Drs. Spencer Dorn and Jonathan Hansen remain in our Division as junior faculty members and thus keep their current caseloads.

For the year 2010-2011, Drs. Sid Barritt and Millie Long remain in our Division as junior faculty members and thus keep their current caseloads. Allan Hardy's patients can go to Brock Miller.

Former residents at UNC coming into our subspecialty residency training program need to make sure that their former patient caseloads have been transferred to the appropriate resident.

POLICY ON PATIENTS WHO WISH TO SWITCH PHYSICIANS WITHIN OUR PRACTICE

It is our policy that if a patient calls requesting a change to another physician within our group because of, for example, dissatisfaction with care or not getting better, that we do not automatically accommodate such a request. We are a tertiary referral center, non-primary care group practice. There is an expectation that all of our physicians provide excellent patient care, in keeping with our mission and vision, and, as such, we must all support one another. If a patient calls with such a request, they will be told that their physician will be notified to discuss the issue further with the patient. In many cases, the physician is not even aware there is a problem, and often discussion can solve the problem. If, after discussion, the patient still wishes to be seen by another care provider, the physician has two choices: 1) Discuss case with an appropriate UNC provider and see if they would be willing to see the patient, or 2) Advise the patient to seek a second opinion from a gastroenterologist from outside the UNC system. If this is the case, transfer of records can be made.

Women's Health Research Day: The Center for Women's Health Research at UNC (CWHR), located at 725 MLK Jr. Blvd., Suite 282 (Campus Box 7521), sponsored its tenth annual "Women's Health Research Day" featuring excellence in women's health research on Tuesday, April 7, 2009 from 4:30 – 6:30 p.m. (opening reception and poster session) and Wednesday from 8:30 a.m. to 4:30 p.m. at The Friday Center. For information, visit <http://www.cwhr.unc.edu> or phone 6-7928.

The committee of jurors invites submission of research abstracts of excellent quality in all areas related to women's health. Authors with original research are encouraged to submit abstracts in any domain of women's health research including: basic science, clinical, translational, prevention and health behavior, epidemiology, social sciences, and health services research, including health policy and health disparities. All abstracts are reviewed by a committee of jurors from inside and outside the University and judged for originality of research, scientific rigor, and salience to women's health. This year, deadline for receipt of abstracts was 5 p.m. on Monday, December 8, 2008. Reviewers' decisions were provided to the presenting author by Friday, January 23, 2009. Research was selected for either a podium presentation or the poster session. Posters were displayed during a reception and poster session on the afternoon of April 7th and throughout Research Day on April 8th. Winners received \$1,000 and \$2,000 cash awards.

Please follow these instructions for the preparation of abstracts:

1. Abstracts should be structured and include: Background, Objective(s), Methods, Results, and Conclusions.
2. In the upper left-hand corner, state the paper title (in ALL CAPS AND BOLD), the presenter's name, title, address, phone and fax numbers, email address, and institutional affiliation. The title of the abstract should not exceed 100 characters.
3. Beneath the presenter's contact information, provide the full list of authors by last name with first and middle initial: e.g., Jones KE, Davis AB, Smith LI.
4. The text of the abstract (title and author list not included) may not exceed 350 words.
5. Please double space with at least 11-point font.
6. Tables and figures may NOT be used within the abstract.
7. A presenter (first author) may not submit more than two abstracts for consideration.

Abstracts may be submitted on-line (preferred) at www.cwhr.unc.edu; via e-mail to cwhr@unc.edu; or via UNC campus mail (with electronic copy provided on diskette) to the following address: Center for Women's Health Research, CB#7521, 725 MLK Jr. Blvd, University of North Carolina,

Chapel Hill, NC 27599-7521. Attn: Kerrie Kurgat. Confirmation of receipt will be provided. Abstracts will be posted at www.cwhr.unc.edu after presenters are notified of abstract acceptance.

The Association of Professional Women in the Medical School (apwim@listserv.med.unc.edu) offers a Women in Science (WOWS) Seminar Series. Interested individuals should contact Patricia Byrns @ pbyrns@med.unc.edu. Dr. Christina Burch advises women professionals on training in the biological and biomedical sciences, cburch@bio.unc.edu, phone 3-2691. Dr. Susan Henning of our Division also advises women professionals on issues relating to basic science careers, sjh@med.unc.edu, phone 3-4969.

CLINICAL RESOURCES

ARTAS/PACS

The number for ARTAS (automated verbal x-ray reports) is 6-6831. To access the hospital PACS system for radiologic and other information, go to <https://pacs.unch.unc.edu>. The Department of Radiology's number is 3-2926.

CIS

The Clinical Information System (CIS) is now web based (as of 5/10/02) (WebCIS) and can be accessed by visiting the following site: <https://webcis.unch.unc.edu>. This serves as our permanent archives for patient medical records since Medical Information Management (MIM) continues to move us from hard-copy medical records to on-line electronic files. The CIS is our most widely used resource data system for care providers who need to review patient demographics, medical records, physician order entry, operating room schedule, and inpatient lists and census. Outpatient parameters include problems, current medications, clinic visits, lab reports, and allergies. A newer feature of the CIS is one in which the care provider can create a message to send to another care provider, with the option to search a recipient under 'select recipient'.

The inception of Web CIS version 2 occurred in May 2003, which began to include direct entry of problems and medications into the CIS at the point of care and time of the patient visit. This has had a significant effect on patient flow. The 'My Dx List' for Medicine/Gastroenterology has been loaded into WebCIS 2.0, drawn from our clinic encounter form. To load common diagnoses, follow the following steps:

- Go to 'WebCIS Admin' in the left frame of WebCIS 2.0.
- Select the 'My Dx List' maintenance link.
- Go to the 'Specialty Preload' at the bottom of the screen and select 'Medicine/Digestive Diseases'.
- Scroll down to the bottom of the screen and click 'Add to my Dx'. This will add the list to that individual's Dx drop-down list on the 'General Problems' tab. If a user does not commonly use certain items on this list, s/he can individually check items and delete them from their Dx list.

On 4/25/05, we upgraded to a new version of WebCIS across the UNC HCS. Two major new services are available: online creation of inpatient consult notes and direct electronic transmission of prescriptions to pharmacies.

New Advanced Care Planning Note

On Monday, March 20, 2006, Dr. Robert Berger, Director of Medical Informatics, sent a memo describing this new feature in WebCIS. One of these is a new “Advanced Care Planning Note.” This new note allows caregivers to document, in detail and in the medical record, the wishes of an individual patient regarding end-of-life care. At present, such information may be difficult to find since relatively few patients have written “advanced directives,” and those who do may not bring them to the hospital or doctor’s office.

The Advanced Care Planning Note should be completed for every inpatient with whom there is a discussion concerning specific wishes about end-of-life care, and/or for every patient who requests “do not resuscitate” status. In other words, the resident or attending physician should document the stated wishes of a patient -- expressed directly or via a family member or duly-appointed decision maker -- at the time of that patient’s hospitalization. If the resident creates the note, the note must be routed to the attending physician for co-signature.

We recognize that it will take time to get used to looking for the Advanced Care Planning Note in our patients’ records. Please remember to start looking for this information, especially when providing “cross coverage” for patients for whom you may not be primarily responsible during daytime hours. Having this information in a specific location in the medical record helps all caregivers to quickly locate the information. As we gradually transition to a CPOE-based “DNR” order, we are moving away from paper orders that spell out specific components of resuscitation. If (and only if) the patient wants to withhold all forms of resuscitation, use the “DNR order” in CPOE. On the other hand, if the patient expresses a desire for some form(s) of resuscitation but not others, the patient is not “DNR,” and you should spell out the patient’s request(s) in the Advance Care Planning Note. Please do not use “orders” to indicate wishes such as “do not intubate” or “do not defibrillate”: these are really *instructions* from one physician to another or other physicians (e.g., those who might respond if the patient deteriorates or arrests), and not “orders” to be carried out by non-physician staff.

In conjunction with the creation of this Advanced Care Planning Note, the Medical Staff Executive Committee has amended our policy on “do-not-resuscitate” orders such that an attending physician is no longer required to sign a DNR order. **Any request for “do not resuscitate” status still requires a physician order; this has not changed.** What has changed is that the resident physician may write the order without an attending’s countersignature. We certainly urge attending physicians to continue to participate in discussions with patients and families about end-of-life care. At the same time, the change in policy makes it all the more important that the resident and/or attending physician document relevant information in the Advanced Care Planning Note for every inpatient who requests “do not resuscitate” status during hospitalization.

When a patient is hospitalized and that patient already has an Advanced Care Planning Note (either created while an outpatient, or during a prior hospital stay), the physician team should do its best to verify that the information in the Advanced Care Planning Note still reflects the patient’s wishes. If the patient’s wishes are unchanged, the physician may simply so indicate in a new note and can reference the date of the prior note.

NPI:

The Federal government now mandates that any health care provider who bills Medicare for services must obtain a new identification number called a National Provider Identifier (NPI). State Medicaid programs and private insurance companies are also converting their systems to identify each of us

using our unique NPI number, so it is clear that any practitioner who bills or who writes prescriptions needs an NPI. Many agencies are also asking for this number to be in compliance with HIPAA. If you bill for services through UNC Physicians and Associates, the practice plan has already obtained an NPI for you through the new “National Plan and Provider Enumeration System” (NPPES). We also apply to the NPPES for NPI numbers for our residents and subspecialty residents.

Most payers, including Medicaid, will (at some point) not reimburse pharmacies for prescriptions unless the physician’s NPI is included on the prescription. Consequently, each of us will need to include his/her NPI on every prescription we write. The original date for “required” use of the NPI was May 23, 2007. However, because many covered entities (physician groups as well as payers) are not prepared to begin using the NPI by this deadline, the Federal government has announced some contingency plans (the details are complicated). You can learn much more about the NPI and about the contingency plan at this web link: <http://www.cms.hhs.gov/NationalProvIdentStand/>.

Because of confusion about the certainty of the May 23rd deadline, it is unclear when pharmacies will be expecting physicians to include their NPI on every written prescription. We have already received a few calls from pharmacies requesting individual NPI numbers and are therefore concerned that you will also get these calls from pharmacies asking for your NPI before a prescription can be filled. In order to minimize these phone calls, we strongly encourage you to include your NPI on every prescription that you write, beginning now. The easiest way to do this is to add your NPI to the default automatic signature line that is applied to prescriptions that you print from WebCIS. Other options -- print new paper prescriptions with your NPI; purchase a self-inking stamp that includes your name and your NPI; or hand-write your NPI every time. **We strongly encourage you to print your prescriptions from WebCIS if you do not already do so.** Not only will this make compliance with the NPI requirements very easy, but it will improve the quality of our patients’ medical records. If you use the e-prescription option -- in which you send the prescription electronically to the pharmacy -- you will also make the process much easier for your patient, since they will only need one trip to the pharmacy to pick up the medicines, instead of one trip to drop off the prescription and another to pick up the pills (you cannot use e-prescription at this time for controlled substances).

To add your NPI to the WebCIS signature line that already prints your name at the bottom of the prescription, do the following (this should take no more than one minute):

1. Log on to WebCIS;
2. Click on “Reference” from the menu at the left side of the screen;
3. Click on the word “Profile” in the upper left section of the screen;
4. A new dialog box should appear that is titled “User Profile”. Click on the option that says “General Settings”;
5. You should next see a screen titled “General Settings”. There is a box called “User Signature:” In that box should already be your name. Under your name type: “NPI: [your NPI number]”;
6. Click OK.

If you have questions about adding your NPI number to your signature line, call the help desk at 6-5647. Remember that with a prescription printed from WebCIS you still need to add your personal signature above the signature line.

What if you do not know your NPI? Faculty -- contact your department's Credentialing Coordinator or Administrator (CADA). Residents and subspecialty residents: Once NPI numbers are issued by NPPEs, your program coordinator is notified.

The most recent version of WEBCIS (2.06) is scheduled for release at the end of June 2007. This new version has many features; highlights include:

1. Medication adjudication on discharge between CPOE and WEBCIS (WEBCIS will be used to prescribe the take home meds and also provide for an updated medication list in the Electronic Medical Record.)
2. Creation of the discharge "Green Sheet" electronically by direct entry. It will be renamed "Brief Discharge Summary" and will automatically bring forward patient demographics, the adjudicated medication list, allergies, and secondary problems from the WEBCIS problem list. Once this Brief Discharge Summary is created, a full Discharge Summary will be available for online entry building on the Brief Discharge Summary, again bringing forward as much electronic information that is already available online such as labs, radiology, procedures (if these have been entered during direct online progress note creation), and operative procedures from dictated/transcribed reports.
3. Direct entered clinic note templates for new and return patients, both "consultations" and non-referred new patients. As in our direct entered progress notes, much of the previous note from the same clinic on the same patient will be brought forward into the next note. The clinic notes will include a templated detailed note quite similar to the inpatient H&P's and consult notes, or the user may choose a free form clinic note which is basically a blank page. These clinic note templates may be adapted to suit the users specialty through the existing "my forms" administrative capability.
4. Improvements in the Health Maintenance modules that will automatically display a link to a lab or procedure that has been done at UNC and set the flag to "done" for that particular entry in the Health Maintenance table. Medications that require scheduled laboratory testing will now be included in the Health Care Maintenance "engine". Department clinical leaders will again be contacted by us to provide the data that they would like to be displayed within the new Health Care Maintenance module.
5. CPOE and the nursing "E chart" application that is now being used on the Pediatrics services will be seamlessly incorporated into WEBCIS and no longer require a separate login and choice of patient. The user will need to just click the CPOE or eChart link on the navy bar of WEBCIS, and those applications will open to the same patient who is being worked on in WEBCIS.

Context-based "HELP" screens within this new version of WEBCIS can help guide the user through the technical and operational aspects of these new capabilities.

Clinic rooms 4 and 8 contain IBM laptops, but not on carts and without local printers. Although these are high-volume rooms, the decision was made to try laptops in those rooms because where the prior computers were located, the physicians had to turn away from the patient to type. Laptops cannot print to a local printer, only to a network printer, hence, no printers in those rooms. It is easier for a physician to hold a laptop on his or her lap when interviewing a patient instead of standing at a cart. All the laptops and computers are susceptible to theft. Laptops need to be charged as well – they are charged each night in a locked location.

There have been reports of an intermittent interface problem between A2K (our appointment scheduling system) and the WebCIS whereby demographic information entered into the A2K does not dump over to CIS. Therefore, the information contained in this parameter may not always be updated or correct.

For questions concerning WebCIS 2.0, please contact Dean Hondros of ISD Training and User Support Services, phone 3-0366, fax 3-0362, email dhondros@unch.unc.edu. WebCIS email address is webcis@unch.unc.edu, and its URL site is <http://webciss.unch.unc.edu>.

NEW RELEASE OF WEBCIS (8/24/09)

We will be releasing a new version of WebCIS Thursday evening on August 27th. This version will have, as its main changes, a completely redone allergy module, a way to create a SOAP progress note (in addition to the “classic” progress note), changes to the problem list that allow for a problem to be noted as an inpatient problem when the patient is admitted, several other changes, and many bug fixes.

You have already received a mailing from the P&T committee a month ago, and another detailed mailing last week with links to tutorials, the P&T documentation, and LMS learning modules discussing the allergy changes. The bottom line is that all allergies in both WebCIS and CPOE will need to be reentered in this new version. This is because there was a major change to the national drug and allergies database that WebCIS and most other EMR’s use to code allergies and we cannot electronically convert the existing allergies to the new database format, thus leaving the institution no choice but to redo all allergies.

Pharmacy documents and LMS tutorials may be found at <http://pharmacy.intranet.unchealthcare.org/> (not available outside the institution).

1. ALLERGIES—NEW: The allergy module has been completely redone per the specs dictated by the P&T committee (see links above). All allergies, both inpatient (in CPOE) and outpatient (in WebCIS), must be reentered under the new format because of this. There are detailed instructions within the help system on WebCIS and each area of the allergy section will have a link to the tutorials explaining details of the process. Selecting the allergy tab will display a list of active allergies as well as other choices, one of which is called “Legacy”. The care giver may use the “Legacy” list as the basis for reentering all **active** reactions to drugs along with taking a new history from each patient. Each drug will have one of two choices as far as reaction: either a true allergy or an **adverse drug effect**. Again, the P&T committee has available a teaching module in their link to help the user decide which category to select when entering the allergen. CNAs, LPNs and others, who by “scope of practice rules” are not licensed to put in **verified** allergies, may put in allergies/reactions in an **unverified** state. Physicians, RNs, FNPs, LIPs, etc. should verify these allergies, which will remain in an unverified state until such verification occurs. A prescriber will **NOT** be able to add or prescribe a drug until all allergies are in a verified state. Likewise, if **NO** active allergies are entered (including NKDA), the prescriber will not be able to add or prescribe a med until something is entered in the active allergy section.

Allergies entered in CPOE or WebCIS will now flow from one to the other application instead of the previous flow, which was just from CPOE to WebCIS, but not the reverse.

2. **SOAP NOTE—NEW:** Due to the complexity of the allergy changes above, we will be postponing the release of the new SOAP note for about two weeks after this version is first released. However, when released (I will be sending you a notice that it is available) a new inpatient progress note called the “SOAP” note will be included in the create notes section and appear under inpatient progress notes in the report section. Per direction from the Chief of Staff, a chief resident group chaired by Professor Matt Ewend that designed this note, and the house-staff council, this note is the preferred note to enter daily progress notes. The note should be succinct and the user will find that the most recent vital signs, meds, labs and radiology studies will automatically populate these notes. The radiology and lab procedures will default results from the last 24 hrs with the radiology list containing the date and name of procedure. A hyperlink from the radiology procedure name will show the full report with its own link to the image itself (both in the finished note and during the creation of the note). Any med, lab, or radiology procedure must be checked (in the checkbox to the L of the value) if desired to be included in the final report. The user may still click a button that brings the subjective areas forward from the previous day’s progress note if desired. This SOAP note will be available under “my forms” to create default language in some of the subjective fields of the note, similar to other “my form” notes. The old “classic” inpatient progress note will still be available for use, but is not recommended unless the user can be succinct and make sure that any language carried forward from previous days’ notes is checked for accuracy to reflect what is occurring on the given day the “classic” note is written. It is recommended that a new SOAP note is started only with new admissions and to continue the old progress notes for the current inpatients, since there is no data propagation across those 2 notes.
3. **PROBLEM LIST--ENHANCED:** The problem list now contains a column to reflect whether a problem is an outpatient or inpatient problem. Once admitted, the user should go the list and change an existing problem to an inpatient problem. These problems will automatically default the new SOAP progress note under the A&P section. On discharge, all active problems will revert back to an outpatient state. A new problem may be listed under active problems even if it is present under “charge entered” problems.
4. **TRANSCRIBED CLINIC NOTES—PRINTING:** Transcribed clinic notes (only in the reports section but not the visit section) can be printed in a professional appearance instead of as a Web Page. A “printable version” link to do this will be found in the upper R hand section of the report.
5. **SURGICAL GLOBAL PERIOD CHECK BOX:** Surgical Global period check box will appear for transcribed notes as well as attending direct entered notes, and limited to H&P, Progress, and Discharge Summary Notes.
6. **EKG IMAGE LINK:** EKG images are available as a link from the EKG reports (click on icon in first column). This has already been instituted in the existing version.

7. END USER REFERENCE: Both allergy and med sections will list the last person to have edited those areas.

New Release of WebCIS (6/28/10)

Main New Features

1. *Inpatient Coded Problem Lists*

To improve our morbidity and mortality data with better coding of co-morbidities as well as providing for the **first time** a coded inpatient problem list on the H&P the following changes and processes have been made:

The “My Dx” list will be expanded to allow for a finite (30-100 or so) number of top diagnosis and co-morbidities based on each individual inpatient service. Within these lists, there will be 28 “global” Dx’s applicable to all services. Some services have already given us their complete list (in English, not “ICD-9 speak”) but many have not. Those services that have not provided their individual Dx’s will contain the 28 global Dx’s, but over the next two months we expect all services to have provided their unique Dx’s to the lists.

To load a specific inpatient problem list, at the bottom of the “My Dx” administrative section you will see both an inpatient and outpatient drop down list, ordered by Dept/Division for the outpatient list and Hospital Service for the inpatient lists. An incoming licensed provider to that service will be able to choose to add these Dx’s to their personal “My Dx” list (and also remove them when they go to the next inpatient service). We will continue to have an outpatient “starter” list that can be loaded based on Department/Division. The main display when clicking “My Dx” administrative area will show whether the Dx is inpatient-based or outpatient and which service or Dept/Division the particular Dx came from. To delete added Dx’s, the user can either hit a “garbage can” icon next to the first new entry from a given service on their main list, or pick the service again from the bottom of the “My Dx” administrative area, and hit the remove button.

Once your “My Dx” list has been updated by the above process, we expect all users when doing an initial H&P, under the A&P section to hit the button that says “Add/Inactivate Problems” which will take them to the problem list. From there, you can use your inpatient Dx list dropdown to pick a problem or problems to add as active to the main problem list. If there are existing problems on the problem list, you may also check or uncheck them as being active for the given admission. If you have only added active problems by using the dropdown My Dx list, you may hit the button that says “H&P note Assessment/Plan”, which will take you back to your H&P and you will see the active problems that you have chosen present with a statement underneath that says **“present on admission”** and a text box for details next to them. If you make an existing problem active by checking the button under the “current” column while in the problem list, you must first save the changes, and then return to the H&P in the same manner as above. The SOAP progress note already contains this facility to be able to add a problem should it occur after admission and should be used for this purpose, however there will be no notation that the problem was “present on admission” in this case (the assumption being that the problem occurred during the admission).

This whole process is crucial to improve our case mix statistics, increase our reimbursement both on the hospital and P&A side, and to allow us to program in the future many additional automatic clinical decision support rules within WebCIS since we will have coded Dx’s right off

the bat for an admission. We will be streamlining the computational part of this process in a version of WebCIS to be released this fall to allow all of this to be done from within the H&P note itself without preloading specific services to the “My Dx” administrative section, and without going out to the problem list.

2. *ICU Progress Note*

A new ICU progress note will be present and preloaded with information from e-Chart, CPOE and labs (similar to the SOAP progress note) but with many other fields per specs from the surgical ICUs. This note can be used by non-surgical ICUs that feel it meets their needs.

3. *ePrescribing Self Registration*

Surescripts ePrescribing self registration will be totally revamped with all required fields prefilled (from our master “PRDOC” credentialing file) and the user will automatically be registered. All the user needs do is to verify the information is correct by going to the administrative area of WebCIS and choosing “ePrescription Provider Profile”. If it is not correct, information will be given on who to call to get the proper information loaded or updated into the credentialing file, and by the next day the user will be automatically registered for ePrescribing. If a user has not successfully been registered by this automated process, a message will come up when attempting an ePrescription that directs the user what process to follow to get them auto-registered by the same process as described above.

4. *Pressure Ulcer Present On Admission*

A check box will be present, only in the FIRST progress note, (whether it is a SOAP progress note, “classic” progress note, or ICU progress note) that will capture data from the nurses’ admission documentation in e-Chart of a “Pressure Ulcer present on admission”. If a pressure ulcer is present, the details of location, stage etc. will be prefilled and by checking the box, the physician will attest that they have confirmed the nurses’ findings. This will increase reimbursement (particularly from Medicare) as currently if there is no documentation of a pressure ulcer present on admission and later a pressure ulcer is described, the whole admission reimbursement may be denied. It is expected that if a physician did not notice a pressure ulcer that was documented by the nurse, and they have checked the acknowledgement box, that they examine that patient’s pressure ulcer.

5. *Rounds Report – Extended Vital Signs*

This version will contain the promised extended vital signs from the ICU’s to show up in the Rounds Reports and the SOAP and ICU progress notes. These parameters will include such things as Ventilator Settings, CVP, ICP, PA wedge pressures, RASS score and several others.

6. *Imaged Documents Enhancements*

Imaged documents will contain ALL “patient level” documents with a scan date, e.g. Advanced Directives, External Records, as well as accurate “visit level documents” with a scan date and a “visit” (either inpatient or outpatient) that corresponds to the imaged document.

7. *Additional Features*

Multiple smaller new functionality, such as correct insulin instructions passing to WebCIS and e-Chart from CPOE on Med Adjudication at discharge, inclusion of PPD documentation under the “immunizations” tab, and chemo orders modification/additional breast protocol templates will be in this version.

You will notice a couple of other things in this version. In preparation for electronic renewals of prescriptions there will be an icon that is a pill bottle on the left Nav bar next to the phone message and other alerts icons. It will always read “0” until we activate the process in the next version of WebCIS. You will also see an entry in the tabs in your activity list that says “renewals” which will be empty again until we activate the application that will allow electronic renewals of prescriptions in the next version of WebCIS. The “Summary” tab on the activity list will have a completely different look and feel to it which should be self explanatory.

Unfortunately, you will again see Meds within the Med list and within your “My Rx” list that will be highlighted in orange. The pharmaceutical industry again has changed many of their drug codes. This has resulted in many drugs on the latest database of all drugs that we have loaded both in WebCIS and CPOE having different “back end” codes than the previous drugs. We use these codes to do our allergy checking, drug interactions, and ePrescribing. Therefore, you will need to reload any drug in either the patients’ Med List or your “My RX” list that is in orange. Hopefully this will be the last “big” change from the pharmaceutical industry that will cause this, however, each month we get a new database, but we expect little impact from this point on. The good news is that over 8000 new drugs will be available in WebCIS.

As always, you may call the Help Desk if you would like individualized training from our support group for these new modules in WebCIS and don’t hesitate to contact me at rberger@unch.unc.edu for questions or comments.

Consult Services

For physician consult services, you may call Carolina Consultation Center at 6-4005 (800-862-6264) in addition to Health Link (6-7890) and Health Touch (6-0000). Besides use of alphanumeric pagers, internal pager messages through the hospital paging system can be created on the WEBXchange (intranet web directory) at <http://directory.unch.unc.edu/webxchange>. One can also find a physician by going to http://www.unchealthcare.org/find_a_doctor/index.cfm or by going to http://www.pagenet.com/sendamessage/One-Way_Local.html. In this latter site, where it says ‘select messaging terminal’, choose ‘Raleigh’ (not Greensboro). Where it says ‘messaging address’, put in the pager number, with no hyphen. One can put up to a 240-letter message in the box and click on ‘send’. This web URL and others can be bookmarked for future use.

Additionally, one can go to ‘Arch Wireless Send a Page Online’ by going to <http://www.arch.com>, selecting ‘send a page’, entering one’s alphanumeric pager number in addition to the area code, and keying in a message of 200 characters maximum.

One can also look up physician information through the North Carolina Medical Board (NCMB) at www.ncmedboard.org/database/search.asp as well as through our Web CIS to the left of the home screen under ‘reference’ and then ‘provider’ where one can locate a physician by last name, first name, MD code number, city, state and zip code. Once you find a physician by ‘provider lookup’, the ‘provider profile’ includes the physician’s address, office phone and fax number, and preferred method of correspondence.

If a physician or his support staff has access to the A2K (SMS) scheduling system, s/he can find physician information by going into option #45 (profile inquiries) and then entering option #1 (provider master file), which will allow the person to look the physician up by name, UPIN #, or MD code number. There is also an option at the bottom of the screen that allows one to choose how much information s/he wants displayed.

If you have a PDA and would like to add select pager and office numbers of UNC staff to it in a searchable form for your use, you will have to purchase the HanDbase program for your PDA. The hospital telecommunications office will email you a file with all the names that you can download into the HanDbase. Whenever you want—say yearly—you can have telecommunications send you an updated file to overwrite the old one. For this service, you may contact Tom McCotter in hospital telecommunications at 6-1670 or mccotter@unch.unc.edu.

UNC-Hospitals has implemented a system to provide phone assistance for those trying to contact individuals within the hospital by dialing 2-6643 (A-N-N-I-E), 24-hour service. From outside the hospital, dial (919) 962-6643. A-N-N-I-E is a service provided by the UNC-Hospitals Telecommunications Department.

CPOE

Computerized Physician Order Entry, initially located on the floors, is now located in all clinics. The newest version of CPOE streamlines the quick entry of orders based on “order sets” and improves searching capabilities for tests and drugs. A new version of POE allows for orders to be “parked” for later activation (such as preops or transfers) and provides for “unverified” orders to be placed by a medical student or trainee for later activation and countersignature by housestaff or attendings.

On April 11, 2006, CPOE underwent an extensive upgrade, with the following changes:

- Diets/NPO upgrade: Diets are combined into one category – **Nutrition Food Services** – and are **revisable**.
- Transfusion Orders updated – Electronic order replaces paper form: The paper form is no longer needed for CPOE users or by the Blood Bank when filling a blood order for a CPOE patient. Search on TRANSFUSE under ‘ordersets’. Tips appear in these ordersets when hovering over a field or button on the screen.
- Medication Companion Orders: Some medications now automatically include companion lab orders. For example, when ordering amphotericin, a companion nurse draw order is created for CBC, NA, K, BUN, and creatinine at 24 hours after the first dose and another order created at 72 hours. See ‘Detail’ button that has been added to the ‘Current Orders’ display. Under ‘Current Orders’ or ‘All Orders’, click the ‘See Detail’ button in the bottom left corner to expand the display of current orders and the order detail information. Click ‘See Summary’ to condense the list back to its original view. ‘Current Lab Orders’ and ‘Current Med Orders’ tabs have been added to the ‘Current Orders’ display. Two additional tabs have been made available on the ‘Current Orders’ tab for more efficient access to labs and medications. Click the ‘Current Lab Orders’ tab to view a lab-only display or ‘Current Med Orders’ to only see current meds for the patient sorted alphabetically.
- The ‘Reprint Function’ has been added to the ‘Navigation Bar’: ‘Reprint’ has been moved to the Navigation Bar for quick and easy access by clicking ‘Reprint’.
- ‘Additional Comments’ fields have been added: Two additional free-text fields have been added to the Nursing Orders set-up screen to give more space for comments.

Beginning on Saturday, September 30, 2006, clinicians who write orders have the option to directly enter a “do not resuscitate” order in CPOE. A paper “DNR” order will still be accepted as an alternative, and for now there is no specific timetable to eliminate the paper DNR order, but over time we expect to migrate all DNR orders to CPOE.

Please note that the DNR order in CPOE is just that – “do not resuscitate”. There is no provision to order some forms of intervention that we consider resuscitation, but not others. Therefore, the DNR order in CPOE should be used only when you are satisfied that the patient’s wish is not to be resuscitated in the case of a cardiac or pulmonary arrest, without exception.

For any patient for whom a DNR order is written, a physician member of the care team should complete in WebCIS an Advanced Care Planning Note. Please see <http://medicine.med.unc.edu/uncpa/advancecareplanning.doc> for a fuller description of the Advanced Care Planning Note, introduced to WebCIS in spring 2006. Remember that effective April 2006, a DNR order does not require an attending physician’s signature. This makes it all the more important that (1) the resident and/or attending physician document the patient’s wishes in an Advanced Care Planning Note and (2) if the resident creates such a note, that it be routed to the attending physician for review and co-signature.

If a patient expresses a desire for some forms of resuscitation but not others, do not use a “DNR” order, either in CPOE or on paper. Instead, document the patient’s specific wishes in the Advanced Care Planning Note. Additionally, the Advanced Care Planning Note contains space for several different types of information. You do not need to fill in every section of the Note, but you should document those parts of the discussion that you think are relevant.

When a patient is hospitalized and that patient already has an Advanced Care Planning Note (either created while an outpatient, or during a prior hospital stay), the care team should do its best to verify that the information in the original Note still reflects the patient’s wishes. If the patient’s wishes are unchanged, very briefly indicate this in a new Note and reference the date of the prior document.

The Blood Bank is receiving a large volume of orders for Type and Cross when patients already have units prepared and ready to transfuse. This happens when a primary provider has ordered multiple units for type and cross, transfuses only some of them, and then orders another transfusion with both Set Up and Transfuse amounts valued. In order to help improve CPOE ordering services for Transfusion Medicine, on the CPOE Transfusion screen:

“Blood Component Setup Quantity” represents the amount for the Blood Bank to type and cross;
 “Transfuse on this order Quantity” represents the amount to be transfused NOW.

If the patient already has units in the Blood Bank and you need to order transfusion, please click the “Transfuse Per Prior Blood Component Order” box and enter **only** a “Transfuse on this order Quantity.”

Nutrition & Food Services needs help to ensure that patients’ diet orders are current and accurate. **When a diet order needs to be changed in CPOE, the current diet needs to be “revised” from “Current Orders” rather than entering a new diet order or discontinuing a diet.** This saves the ordering practitioner time and ensures that the most current diet order interfaces from CPOE to Computrition (the new computer system for Nutrition & Food Services). For example: The patient is on a heart healthy diet. To change to NPO past midnight, REVISE from Current Orders in CPOE (the Heart Healthy Diet order) to NPO Past Midnight. In the morning, if the patient’s diet order is to be changed again, then the practitioner REVISES the NPO Past Midnight order to the Heart Healthy Diet (or whatever diet the patient is being changed to at that time).

For safety reasons, when discontinuing a diet order in CPOE, it sends a message to Computrition as “No Diet” through the interface. Computrition does not revert to any previous diet order. Only

the last entered, revised or discontinued diet is active/retained in Computrition. Thus, it is imperative that diet orders be revised to ensure patients' diet orders are accurate.

Pneumococcal vaccination for inpatients

In a concerted effort to improve our pneumococcal vaccination rates – specifically – our efforts to identify and vaccinate individuals while they happen to be inpatients (not clinically intuitive but now required by Medicare), previously, many clinicians have been identifying eligible inpatients, screening for (rare) contraindications, and, when appropriate, ordering the pneumococcal vaccine.

Now, in order to make the process more effective and efficient, we are converting to the use of a “standing order” for administration of pneumococcal vaccine to appropriate inpatients. The Medical Staff Executive Committee approved the use of this standing order at its April 2007 meeting. Effective immediately, staff from the Performance Improvement and Patient Safety Division, in collaboration with Nursing staff, will take over the process of identifying potential pneumococcal vaccine recipients. These individuals will also obtain the appropriate screening history. Unless they confirm recent prior vaccination or a specific contraindication, Nursing staff will administer pneumococcal vaccine and will enter the vaccine order as a standing order in CPOE.

Please note: The standing order will be recorded in the name of the patient’s attending physician. The attending physician will not have to sign the order in CPOE.

CPOE Enhancements for June 25, 2007

Change Order Set View: A new function off the physician navigator that will allow the clinician to change their default order set view instead of calling the helpdesk.

Transfusion Orders (Blood Component Orders): The clinician will be presented with options on what (s)he wants to do with blood products: Transfuse (order for RN to Administer product), Set-up and Transfuse (order to blood bank and RN to administer product), Set up only (order to blood bank to set up) Set-up for OR (order to blood bank to set up for OR). Once an option is selected, CPOE presents only required fields for that are needed to complete the order.

Adult TPN Orders: The clinician will be presented with a decision tree when ordering adult TPN: Standard, Total Calories Calculation or Grams Calculation. As of Monday, June 25, 2007 no paper TPN orders for adults should be written. Please contact the Adult TPN/PEN service for clinical operational questions.

Discharge Medications: A new function off the physician navigator that will allow the clinician to select discharge medications from the patient’s current medication profile in CPOE to be sent to the WebCIS Discharge Medications list. This function will be available with the 2.9.06 release of WebCIS.

Orders that Expire in 24 hours tab: A new function on the current orders display that displays orders approaching expiration within the next 24 hours.

Hospital ISD User Support representatives are available to assist care providers with issues relating to CPOE; the Help Desk number is 6-5647.

Hemochromatosis Testing

On 6/5/03, UNC Healthcare sent a memo to clinicians in GI and hematology stating that, effective 6/11/03, the molecular genetics laboratory has changed its method used for testing of hereditary hemochromatosis. The test is now performed by real-time polymerase chain reaction (PCR)

followed by melt curve analysis on a Roche Lightcycler. Previously this test was done by PCR followed by restriction enzyme digestion and gel electrophoresis. The procedural change has not affected test results. Further information on clinical utility can be provided by calling the Molecular Genetics Laboratory at 6-4408 or by visiting their website at <http://www.pathology.unc.edu/labs>.

Hereditary hemochromatosis is among the most common genetic diseases in the US, affecting about one in 200 Caucasians. The biologic basis is often HFE gene mutation, resulting in amino acid substitution in the beta-2-microglobulin binding domain, causing failed coexpression with the transferrin receptor on the surface of the gastrointestinal epithelial cells, high dietary iron absorption, and iron overload in many organs. About 90% of hereditary hemochromatosis patients have the homozygous C282Y gene mutation. Compound heterozygotes for C282Y and H63D tend to present with milder cases of the disease.

Diagnosis of hemochromatosis is often difficult due to the variety and non-specificity of symptoms. Iron overload may manifest as heart failure, cirrhosis, arthritis, diabetes, joint pain, diminished libido, skin bronzing, or most commonly, as chronic fatigue. The mutation is incompletely penetrant in that only 25% of homozygotes develop disease-related mortality or evidence of liver damage. Population screening for HFE gene mutations is not warranted. Instead, genetic testing should be limited to patients with evidence of iron overload. Laboratory tests for iron overload include transferrin saturation, serum ferritin, and liver biopsy. It is cost effective to begin work up with transferrin saturation and, in those patients with significant iron overload (saturation > 45%), proceed to mutation testing to assess the primary versus secondary nature of the disease so that appropriate therapy may be given. Detection of HFE mutations has implications for blood relatives who are at increased risk for carrying the same altered genes. Genetic counseling is available by calling 6-4202 to make an appointment.

Hospital Contact Numbers

Our GI Medicine Clinic number is 6-6000 (toll free 1-877-668-0680), fax 3-2633. Our GI Procedures number is 6-5563, fax 6-8764. Our GI Surgery Clinic number is 6-2225, fax 6-9345 (administration 6-4389, fax 6-8440). The number for Pediatric Gastroenterology is 6-1343, fax 6-8641.

The hospital operator number is 6-4131. The number for our bed management center (admissions) is 6-2041 and for clinical resource management 6-5264. The hospital motel's number is 6-1241.

The number for patient information is 6-4311, medical information management 6-2314, release of medical information 6-2336 (fax 6-6295), and patient core labs 6-2361.

The general number for Ultrasound is 6-0034 and for appointments is 6-1884.

IBD

There is much information about IBD: www.elan.com, www.ccfa.org, www.rxhope.com (prescriptions), www.healingwell.com (general information), www.uoa.org (ostomies), www.panix.com/-nomilk (the no milk page), www.ibdtrials.com (clinical research trials),

www.remicade.com. The Crohn's and Colitis Foundation's (CCFA) toll free number is 800-932-2423, with recent additions including a teleconference series www.ccfa.org/webcasts and Facebook <http://apps.facebook.com/supportccfa>. *Inflammatory Bowel Diseases* serves as the official journal of the CCFA and can be found at www.ibdjournal.com. *Under the Microscope* is the seasonal research news bulletin from the CCFA. Founded in 1967, CCFA's mission is to cure and prevent Crohn's disease and ulcerative colitis through research and to improve the quality of life of children and adults affected by these diseases through education and support. Currently CCFA is comprised of 42 chapters nationwide with 300 support groups and to date a total of 32,000 requests for support and 1,000,000 pieces of literature produced. The CCFA web site alone gets over 100,000 visitors each month. CCFA has invested approximately \$127 million towards the world's most cutting-edge research, science that has already significantly improved the quality of life for people living with IBD. Despite such advances, there is yet a known cause for Crohn's disease or ulcerative colitis, and no one medication exists that works for all patients. At www.ccfa.org, viewers can retrieve information archived on the CCFA website, such as nutrition and IBD, which contains advice from a nutritionist and even a selection of recipes created by IBD patients, for IBD patients. These programs are sponsored by such Pharmaceuticals as Biogen, Elan, Proctor & Gamble, and Solvay. If one is interested in finding out about the latest clinical trials online, s/he may visit www.ccfa.org/clinical. Interested individuals can request periodic news updates provided by CCFA by emailing news@ccfa.org. Our IBD Center publishes announcements of and updates on current trials being conducted in the *Inflammatory Bowel Disease Studies at UNC-Chapel Hill Newsletter*. For the first time on Saturday, April 28th of last year, we sponsored an 'IBD Education Day' from 9:30 AM to 2:30 PM at the Friday Center, with over 270 individuals in attendance. The event was held again this past year on Saturday, May 3rd, with over 300 participants, in addition to a follow-up IBD Update on Saturday, September 12th, with 360 attendees. Additionally, Dr. Hans Herfarth has created a web site devoted to IBD patient education, which provides an overview of the digestive tract and explains the provenance and nature of ulcerative and Crohn's colitis. The URL for this web site is <http://www.ibdunc.org>. This site is sponsored by an unrestricted educational grant by Proctor & Gamble. "Understanding Inflammatory Bowel Diseases: What Every Patient Should Know," sponsored by Centocor, was held on Wednesday, June 24, 2009 from 6:00 PM – 8:00 PM at Wake Forest University Baptist Medical Center in Winston-Salem. The CCFA is delighted to announce this new program for patients, families and caregivers living with Crohn's disease and UC in the Piedmont-Triad area. Topics of discussion included a) an overview of IBD, b) recognition of symptoms and the importance of diagnosis, c) review of current therapies and emerging research, and d) management of disease, emotional wellness and resources. For additional information regarding this program, please contact Tewanna Sanders at 704-332-1611 or email her at tsanders@ccfa.org. UNC sponsors a joint IBD Journal Club with Duke on a quarterly basis, this year at Maggiano's restaurant at Southpointe, made possible by UCB, Inc. The format is loose, in which case presentations, journal article reviews, and research presentations are combined. This is a great opportunity to meet colleagues at Duke to network, and several interinstitutional collaborations have resulted from previous meetings.

Approximately 500,000 Americans are currently diagnosed with ulcerative colitis. Living with this condition can, without a doubt, be physically and emotionally taxing. The recurring abdominal pain, diarrhea and rectal bleeding are certainly challenging. By becoming more informed, an individual with UC can take steps to better manage his or her condition. In addition, knowing more about UC can help facilitate the nature and flow of communication between the patient and his or her physician. For UC patients, the unexpected flare can be extremely stressful. Patients can now assume a more active role in managing their UC by enrolling in a program of information and support at <https://www.managingUC.com>. As a program member, the patient receives an article containing practical solutions and important information that addresses the emotional aspects of

UC, with the primary focus being the initial and paramount importance of developing a relationship between emotions and condition. The patient then learns proactive steps to help manage his or her symptoms. This website has been created to help patients get the facts about what they should know about UC and how this knowledge can help them partner better with their physicians and healthcare teams. Information centers on the patient's recognition and awareness of the relationship between stress and condition, what steps the patient can take to better manage symptoms, and where the patient can go to obtain more assistance. Patients can also refer to a more recently established web site: <http://www.livingwithuc.com>. In addition, www.CrohnsAndMe.com is a website created especially for people whose lives are affected by Crohn's disease – patients, friends and family. This site includes helpful information regarding Crohn's disease and useful tips for easier daily living. It also stresses the important of building networks and support groups; thus, individuals with Crohn's disease can make connections with other individuals with CD. In the same manner, individuals who have loved ones with CD can connect with other individuals who have loved ones with CD. In addition to helpful information on Crohn's disease and tips for daily living, the site has unique features such as video stories from Crohn's patients and a Crohn's tracker to help record symptoms. The *Crohn's Disease Newsletter* is located at 1950 Lake Park Drive in Smyrna, GA 30080, email return@grandstringer.com. The current prevalence of CD is 100-250 cases per 100,000, with between 600,000 – 800,000 cases in the US. To become a member of "WE CARE IN IBD," please request an application by writing to WE CARE in IBD Membership, c/o Manning, Selvage & Lee, 303 East Wacker, Suite 418, Chicago IL 60601 or faxing a written request to 312-861-5252.

In addition to sponsoring "Meet the Mentor IBD Luncheon" for fellows to network with national IBD specialists and receive individualized instruction, Shire offers a US GI Patient Assistance Program. Please information contact Shire at 866-325-8224 (fax 866-838-5915) or send correspondence to PO Box 722, Somerville, NJ 08876.

As data on the management of IBD continues to evolve, so do the treatment and management strategies among practitioners. "Expert Insights in the Management of IBD" provides a series of informative dinner meetings practitioners might find useful in their approach to patient care. To register or learn about this series, visit www.IBDcme.TV or call 973-867-3684.

CCFA's National Scientific Advisory Committee (NSAC) awards grants through a peer-review process on the basis of scientific merit and relevance to inflammatory bowel disease. The Foundation's 'Naming Opportunities Program' allows donors to fully or partially underwrite a scientist who is working on research to find a cure. Awards granted include a Research Fellowship Award, a First Award, a Career Development Award, and a Senior Grant. In addition, there is the Solvay Pharmaceuticals Student Research Fellowship Award and the Procter & Gamble Young Investigator Award. These awards help provide funds for students to conduct research with a mentor, investigating a subject relevant to IBD. The two winners of the Procter & Gamble Young Investigator Award are recognized at the annual meeting of the AGA held in May. These prizes are given to investigators who performed outstanding basic or clinical research relevant to IBD. They have submitted a first authorized abstract to a national or regional research meeting. Recipients are selected among fellows, non-tenured track faculty, and first-year tenured track faculty members.

Area support group meetings for people with IBD include Charlotte (704-907-9374), Gastonia (704-834-3565), Greenville/Spartanburg SC (864-473-1007), Kernersville (336-591-8208), Monroe (704-291-9678), Raleigh (1-888-455-3338), Rock Hill SC (803-628-5095), Shelby (704-434-0054), Triangle Youth Group (919-819-8651), Valdese/Morganton (828-439-9230), Wilmington (910-371-9522) and Wilson (252-237-5718). Support may also be found by visiting <http://www.healthtalk.com>.

Additionally, News and Views is a quarterly publication for CCFA constituents in North and South Carolina. Liz Selisker has created the Triangle Immunology Interest Group comprising monthly seminars promoting collegial interactions and stimulating collaborative research among Triangle-area immunologists and those interested in immunology. Local companies and universities representing all levels of training are welcome. These are held at the North Carolina Biotechnology Center at 15 T.W. Alexander Drive in Research Triangle Park, NC 27709, with pizza and an informal social from 5:30 – 6:00 PM followed by a seminar and discussion from 6:00 – 7:00 PM. Driving directions include www.ncbiotech.org/about_us/regional_offices_and_directions/directions/index.html. For questions or to be added to the contact list, please email Liz at Liz_Selisker@ncsu.edu.

“CCFA Horizons” is the E-newsletter of the Mid-Atlantic Region. The composition of this region includes chapters from Maryland, Delaware, Washington DC, Virginia, and NC/SC. To obtain monthly news and happenings, email Stephanie Campbell @ scampbell@ccfa.org.

This year, the CCFA presented its first “Team Challenge,” a marathon training program to raise funds to find a cure for UC and Crohn’s colitis. The “Team Challenge” met in Las Vegas NV in December, where runners and walkers joined together for 13.1 miles through the Vegas strip. Information meetings were held in August. To learn more about this event, visit the “Team Challenge” web site at <http://www.ccteamchallenge.org>, contact their Information Resource Center at 888.MY.GUT.PAIN (888-694-8872), or contact Brittany, local Carolinas Chapter representative, at 704-817-7544 (email BdaCosta@ccfa.org).

The CCFA sponsors its annual patient and family symposium, held generally on the third Saturday of February from 8:00 a.m. to 12:30 p.m., hosted by the Carolinas Chapter of the CCFA. This symposium provides an overview of IBD in addition to specialty areas including novel treatments for IBD, women and IBD, diet, surgery, and stress resistance/relaxation. This symposium is made possible by support from Axcam Pharmaceuticals, Proctor & Gamble Pharmaceuticals, and InKine Solvay Pharmaceuticals. The Carolinas Chapter of the CCFA’s email contact is carolinas@ccfa.org or Tewanna Sanders @ tsanders@ccfa.org, phone 704-332-1611 (877-632-1611), fax 704-332-1612, web site <http://www.ccfa.org/chapters/carolinas>. This Chapter has provided numerous patient and health care professional education symposia, with sponsorship from Abbott Immunology & Shire. Their physical address is 2901 N. Davidson Street, Suite 160, Charlotte, NC 28205. On Saturday, November 14, 2009 from 8-11 PM, this Chapter hosted its 6th Annual ‘Paint the Town Red, White and Blues’ at the Wachovia Atrium in uptown Charlotte, an evening of charity and awareness, featuring local art, live entertainment, and catered food. The contact person for this event is Mary Nethercutt, mnethercutt@ccfa.org. Additionally, this year our Chapter participated in a new event called ‘Take Steps’ for Crohn’s & Colitis on June 6 at Lake Crabtree County Park from 4 p.m. – 8 p.m. The event consisted of walk for family and friends, with food and related activities. Take Steps is created to provide an increasing awareness of Crohn’s disease/UC and raise funds to bring an end to these diseases. The web site for the event is www.cctakesteps.org/raleigh.

For the academic years 2006-2011, the CCFA chose the IBD Center of UNC Gastroenterology as one of nine national Center programs to host a second- or third-year GI fellow from outside institutions to visit our program for a one-month rotation, with a maximum of three residents from other institutions per year. The goal of this arrangement is for physicians at non-IBD Centers to learn more about current trends in the diagnosis, treatment and management of ulcerative and Crohn’s colitis by visiting our Center, recognized as one of our nation’s “Centers of Excellence.”

The Foundation for Clinical Research in IBD has a web site, which can be found at www.clinicalresearchinibd.org. This foundation is a nonprofit organization, incorporated in the

State of New York as a 501(c)(3) and governed by a volunteer Board of Trustees. Its mission is to support clinical projects that may have major implications in the management of patients with IBD, to encourage new and provocative concepts that may potentially result in the initiation of clinical studies into the treatment of IBD, and to support clinical therapeutic trials in patients with ulcerative colitis and/or Crohn's disease and their complications. The Foundation also has an ongoing mission to encourage young investigators to pursue careers in clinical IBD and to educate patients and family members about IBD. Featured on the site is information about how to obtain a clinical research grant, senior clinical fellowship opportunities, and "Advances in IBD," a national education program for IBD patients and family members involving top leaders in IBD management.

Sponsored by Imedex, from December 3-6, 2009, the CCFA presented its 9th annual research and clinical conference on "Advances in Inflammatory Bowel Diseases" in Hollywood, FL, www.AdvancesInIBD.com. Last year, the Crohn's Disease Working Group (CDWG) invited applications from GI fellows from accredited US training programs for one-year research awards of up to \$50,000 for original clinical or basic research. These awards were funded by a grant from UCB, Inc. Applications were to be submitted by April 1, 2009, with the announcement and subsequent commencement of awards in June. Further information is available at www.thecdwg.org. Also sponsored by Imedex was a seminar held on September 26 of this year in Chicago entitled "The Management of Women with Chronic Immune Disorders in the Era of Biologics: A Journey from Menarche to Menopause." Scientific topics included

- Healthcare maintenance for immune disorders
- Quality of life and social connectivity for women with chronic immune disorders
- Fertility and pregnancy: the impact of chronic immune disorders and treatments
- Aging and immune disorders: special considerations
- Understanding risk of immune dysregulation and immunotherapy

Interested participants were asked to contact Latasha Milner via email l.milner@imedex.com or phone 678-242-0906.

The Mount Sinai Medical Center hosted its 6th Annual 'Mount Sinai Inflammatory Bowel Disease Consultant's Course: The Evidence and the Experience' on September 25 of this year, www.mssm.edu/cme/courses/ibd.

The University of Pennsylvania sponsored its 7th annual 'Penn IBD Symposium' in Philadelphia March 27-29, 2009. For information, call 215-898-8005 or email penncme@mail.med.upenn.edu. Shire sponsored its third annual IBD Mentor's Luncheon hosted by Dr. Stephen B. Hanauer on Tuesday, June 2, 2009 during Digestive Disease Week (DDW) from 12:00 PM to 2:00 PM at the Firehouse Restaurant in Chicago, IL. The goal of this program is to provide fellows with mentors to assist in their growth and development through their fellowship, with the hope that subsequently this mentoring will guide the fellow into either clinical or laboratory practice. The primary criterion for nomination is a strong interest in pursuing a career in either the clinical or academic study of IBD. All nominations are reviewed by MedReviews, the publisher of *Reviews in Gastroenterological Disorders*. Each mentor chooses a topic related to IBD for discussion at the table. Scholars are encouraged to select the topic of greatest interest to them. At the luncheon, the mentor provides a brief overview on the topic and initiates a conversation by asking a few questions. In this capacity, the mentor can guide the conversation towards an interactive exchange of ideas. Several of our fellows attended the program this past year. Questions can be directed to Nicole Fingerhut, project manager of MedReviews, LLC, by calling her at 212-201-6857 (fax 212-201-6859) or emailing her at nfingerhut@medreviews.com. Interested participants can also contact Anne Balart of Focus

Medical Education by calling her at 504-208-0122 (fax 973-352-6632) or via email at abalart@focusmeded.com.

Collaborations in IBD: A Fellows Mentoring Program is held at the Sheraton Wild Horse Pass Resort in Chandler, Arizona, generally during the first weekend of November (F-Sun). This program is sponsored by the University of Chicago Pritzker School of Medicine, an accredited provider of continuing education for physicians, and is being coordinated by IMED Communications. This program is supported by an independent educational grant from Procter & Gamble Pharmaceuticals, Inc.

In designing this program, collaborators have focused on providing fellows with comprehensive yet practical information on the latest thinking on diagnosing and treating patients with ulcerative colitis and Crohn's disease. Faculty members provide interesting case presentations, which are then discussed. Most of the weekend is devoted to giving fellows ample time to interact with this nationally recognized faculty in small group workshops. They are given material to read prior to the program and are asked to bring their own case studies for discussion.

Seventy fellows are selected to receive scholarships to this important program. Candidates are selected and notified in August. Selection is based on several factors, including the candidate's interest in IBD and the timeliness of the nomination. Preference is given to second- and third-year adult GI fellows, although first-year fellows and pediatric fellows with a strong interest in IBD are also considered. Those selected fly to Chandler, AZ for a welcome reception on Friday evening, followed by a two-day educational program, with departures late on Sunday morning. The scholarships cover the cost of the following items that IMED arranges in association with this educational meeting: round-trip coach airfare, two nights' accommodations at the Sheraton Wild Horse Pass Resort, and arranged meal functions. For questions, please contact L.J. Fiedler of IMED Communications at 908-832-4147 or via email at lfiedler@ascendmedia.com.

Again this past year the AGA Institute partnered with Abbott Immunology in the field of IBD research and education and sponsored a joint program, "Investing in the Future: Clinical Research in IBD" for 15 GI fellows considering a clinical research career in IBD from May 30 – June 4, 2009, in Chicago as part of DDW. The primary goal of this program was to encourage promising fellows to commit to a career in research focusing on IBD. Participants had the opportunity to meet leaders in the field, work with an IBD research mentor guiding them through DDW, attend relevant symposia and presentations related to IBD research featuring expert speakers on scientific publishing, IBD clinical investigations, and IBD biologics, and receive a complimentary registration to the AGA post-graduate course. Abbott Immunology provided AGA with a grant to cover coach airfare, accommodations for five days, DDW meeting registration fees, ground transportation to and from the airport, and selected meals. If you would like more information about this program, please contact the AGA staff liaison at 301-941-2624.

"IBD Watch" is a monthly newsletter produced by a market development group through an educational grant from Salix. For information on how to receive this monthly newsletter, go to <http://www.ibdwatch.com>. The *Inflammatory Bowel Disease Monitor* provides commentary and analysis on advances in the understanding and management of inflammatory bowel disease, www.ibdmonitor.com. The web site www.centerwatch.com maintains a listing of IBD clinical trials in progress. At present, 113 trials are posted, 70 pertaining to Crohn's disease, and 43 pertaining to ulcerative colitis.

IBS

The UNC Center for Functional GI & Motility Disorders publishes a seasonal Digest in addition to an Annual Report. The Group also sponsors ‘An Evening with the Experts’, a monthly online discussion on functional GI disorders, the second Tuesday of every month, from 8-10 pm EST. This comprises an educational chat session open to the public; each session pertains to a specific functional GI disorders topic, likely of interest to many of the website visitors. One can enter the chatroom from our Center web page: <http://www.med.unc.edu/ibs>. Each session opens at 8 pm with an overview given by one of the experts about the topic to be discussed. If you would like to present a special topic or provide one for discussion by others, please call the Center at 6-0144. When indicated, the chatroom can open at 7:45 pm; in some cases slide shows have been presented as an overview to the topic beginning at 8:00 pm.

The Drossman Group offers a seminar for fellows and interested parties, generally on the second or third Wednesday of each month in room 3023 of the Clinical Trials Research Center (CTRC). This is an extremely beneficial and informative seminar on how to effectively manage the IBS patient caseload. Owens & Talley in the Annals of Internal Medicine (1995) set up guidelines in terms of the IBS patient – physician relationship, as follows, in rank descending order of perceived importance:

- Active listening
- Identify concerns
- Explain basis of symptoms
- Reassure
- Recruit patient involvement
- Provide continuity
- Set realistic expectations/goals

This study showed that, with the increased number of guidelines documented by care providers, the number of patient follow-up visits decreased in proportion. Dr. Drossman’s Group encourages care providers to be active listeners, to observe body language with attention to the psycholinguistic components of an individual’s behavior, and to foster independence in the IBS patient. According to the Centers for Disease Control and Prevention (CDC), <http://www.cdc.gov/>, in 2002 primary care practitioners referred 12% of IBS patients to gastroenterologists. Of those, 70% presented with mild IBS, 25% with moderate IBS, and 5% with severe IBS. Within gastroenterology, 28% of the patient caseload comprised IBS patients, while others included PUD 20%, IBD 14%, Liver 10%, Other GI 15%, and Other Functional 13%. In Alimentary Pharmacological Therapy (2002), of 398 IBS patients, there was no change in diagnosis 2-32 years post-diagnosis. In defining IBS as a chronic and recurring disorder, however, of 592 IBS patients, 88% continued to present with symptoms 1-8 years post-diagnosis. In patients with IBS-C or CC, women are affected 2:1 compared to men. In general, health-related QOL is decreased in patients with these disorders. It is estimated that the cost of caring for these disorders is about \$30 billion per year: \$10 billion for doctor’s fees, laboratory tests and medication cost and \$20 billion for indirect costs (loss of work or loss of productivity while at work). Dr. Ami Sperber has created a website about IBS and children through the International Foundation for FGIDs, www.aboutkidsgis.org, 1-888-964-2001.

For those individuals interested in the biopsychosocial model theory first developed by George Engel, refer to the following website

<http://www.human-nature.com/free-associations/engel1.html>. Dr. Engel had quite a strong influence on our program here at UNC in terms of the emphasis on patient-based acquisition of knowledge relating to illness and disease, the importance of skilled interview methods and patient-centered care, the BPS model for research and clinical practice, the Med-Psych Liaison Program with Dr. Eric Jensen in the 1980's, clinical skills evening groups with residents and fellows, and the importance of acquiring both medical and psychosocial expertise to enhance and impact teaching. Dr. Drossman has some tapes with Dr. Engel interviewing a particular patient here (constituting a seminal work), interviewing patients at Medicine Grand Rounds, and interviewing patients at our monthly evening group sessions in the 1970's and 1980's.

It is helpful to know the Rome II diagnostic criteria for irritable bowel syndrome:

Abdominal discomfort or pain for at least three months out of the last year and two out of three of the following:

1. Relieved with bowel movement; &/or
2. Change in frequency of bowel movement (more or less often), &/or
3. Change in form (appearance) of bowel movement (softer or harder)

Symptoms that may be present:

- Abnormal stool passage (straining, urgency, or feeling of incomplete evacuation)
- Passage of mucus
- Bloating or feeling of abdominal distension

The 'Drossman Conference' began 24 years ago as a faculty group to address issues in basic GI care such as the management of narcotics. The GI fellows' group began 7-8 years ago as an offshoot of this monthly conference to provide skills training to fellows in the highly specialized area of functional bowel disorders and irritable bowel syndrome (IBS). This area of GI research involves overlap areas as well such as motility, psychology, inflammatory bowel disease (IBD), post-cholecystectomy pain, temporomandibular joint (TMJ) syndrome pain, rheumatologic pain (fibromyalgia), narcotic/pain management, eating disorders, pharmacotherapy, and obstetrics-gynecology.

The primary goal of the monthly Drossman conference is to provide an opportunity for fellows and other care providers to exchange ideas regarding patient care of IBS to enhance one's fund of knowledge and competence in this area of medicine. The conference does not encourage lectures but instead follows an interactive approach to learning such as active discussions, case presentations, videos, interviewing techniques, and role-playing. In the past, care providers from other disciplines have attended the conference to contribute ideas from their unique perspectives, such as Dr. Charles Burnett, psychologist who specializes in the psychosocial aspects of individuals with functional bowel disorders, and visiting residents from other medical areas, such as OB-GYN.

Participants of the Drossman conference engage in role-playing where people break into pairs of two, one playing as physician, the other as patient. The physician's task is to make a diagnosis based on information provided by the patient. Everyone watches each scenario and provides feedback, which serves as an effective objective measure in gauging mock patient-physician interaction.

Participants of the Drossman conference have the opportunity to study the various personality styles of individuals exhibiting signs/symptoms of functional bowel disorders/IBS. When people are

under stress, as a neurotic response, they may recruit or revert to a certain personality style, which may interfere with and adversely affect their social interactions and interpersonal skills. Participants watch a series of videos demonstrating individuals with the following personality types: 1) dependent, 2) obsessive-compulsive, 3) histrionic, 4) narcissistic-masochistic, and 5) paranoid. Participants initially discuss an outlay of Freudian psychology and the caveat not to focus so much on the personality style as on *how to modify it*. The main question asked of the viewers for their input is, “Why is s/he acting this way?” The viewers are then asked to pay close attention to the *psycholinguistic* elements of the physician-patient interactive process, not only to what a person says, but also the *manner* in which s/he states it (e.g., tone of voice) and, in particular, *body language*. From this approach, often more information can be gleaned from what is not verbalized than from what is verbalized.

In addition to occasional visits by patients themselves, participants of the Drossman conference observe a series of simulated videos with actors who meet with Dr. Drossman. The purpose of these videos is for the viewer to analyze patient-physician interaction and to provide feedback in terms of what *to do* and what *not to do* when a physician meets with a patient. Specifically, viewers observe two differing scenarios, a ‘good’ one and a ‘poor’ one, and are asked to comment on each, respectively. In making a comparison between the two, the viewer is able to discern the positive aspects of a patient-physician interview.

Within recent years, we have begun to incorporate direct patient experiences: patients who agree to meet and tell the group the trajectory of their own medical history and ensuing trials and tribulations. At the end of the patient’s talk, attendees can ask questions and make treatment recommendations. This becomes an open forum that is enriching for the learner and validating for the patient.

In addition to the active exchange of ideas among members of the monthly Drossman conference group, dinner is served at each meeting to bring out a spirit of conviviality and camaraderie. In this socially relaxed setting, Dr. Drossman makes learning fun, and participants are expected to take an active part in each meeting. All feedback is valued and appreciated and serves to help broaden our understanding of functional bowel disorders/IBS and the continued research strides that are being made in this fascinating area of GI medicine.

On Saturday, October 25, 2008 our UNC Center for Functional GI and Motility Disorders again offered a patient symposium entitled “Functional Gastrointestinal Disorders: New Perspectives and Treatments.” This symposium, held every other year at the Friday Center, is designed to educate patients and their families on a multidisciplinary treatment approach to functional GI disorders. The mission of our Center is to advance the biopsychosocial understanding and care of patients with functional GI and motility disorders through research, training and education. The Center is therefore a research, training, education and treatment facility dedicated to the understanding and care of patients with these disorders using a multidisciplinary approach. By integrating treatment with both gastroenterologists and psychologists, the Center is at the forefront of the field in finding bridges between psychosocial stressors and functional GI and motility disorders. Last year’s symposium was co-sponsored by Procter & Gamble, Prometheus, AstraZeneca, Salix, and Sucampo.

On Saturday, June 11, 2005, Saturday, June 17, 2006, and again on Saturday, September 29, 2007, the UNC Center for Functional GI & Motility Disorders sponsored a non-CME symposium entitled “Gastrointestinal Biopsychosocial Research at UNC.” The program traditionally focuses on four areas of research: 1) treatment studies, 2) questionnaire development and outcome assessment, 3) psychophysiological mechanism studies, and 4) pediatric GI disorders. The format for the day

includes presentations on the state-of-the-art in each of these areas by visiting senior scientists, followed by overviews of ongoing studies involving UNC faculty and investigators. Research Day 2006 was held in conjunction with the Center for Gastrointestinal Biology & Disease (UNC Division of Gastroenterology & Hepatology). Research Day 2007 was sponsored by educational grants provided by Sucampo Pharmaceuticals, The Procter & Gamble Company, Takeda Pharmaceuticals, Microbia Pharmaceuticals, and AstraZeneca Pharmaceuticals. Research Day 2008 was held on Saturday, October 4; Research Day 2009 was held on Saturday, September 26.

Resources for IBS:

1. The *International Foundation for Functional Gastrointestinal Disorders* is a patient advocacy group that publishes a newsletter, *Participate*, and can help individuals locate specialty FBD/IBS physicians. Phone: 888-964-2001, www.iffgd.org.
2. *Gut Reactions: Understanding Symptoms of the Digestive Tract*, by W. Grant Thompson, M.D. (Plenum Press, NY & London, 1989).
3. *IBS & the Mind-Body, Brain-Gut Connection* by William B. Salt, M.D. (Parkview Publishing, Columbus, Ohio, 1997. ISBN # 09657038-9-4; www.parkviewpub.com).
4. *Center Watch* (www.centerwatch.com) is an internet service with a comprehensive listing of IBS treatment trials by state (www.centerwatch.com/studies/CAT90.HTM - case sensitive).
5. *IBS Self-Help Group* (www.ibsgroup.org) is an internet self-help group featuring a web-based bulletin and chat boards, book lists, and clinical study listings.
6. *IBS Web Page* (members.aol.com/ibswebpage/ibs.htm) contains a list of online IBS resources.
7. Rome Foundation, 6728 Old McLean Village Drive, McLean, VA 22101; phone: 703-556-9222; fax: 703-556-8729, email romefoundation@degnon.org, web site www.romecriteria.org.

The American Neurogastroenterology and Motility Society (ANMS) offers an exciting training program for gastroenterology fellows and junior faculty on the clinical aspects of gastrointestinal motility and neurogastroenterology that promises to enrich their clinical training and potentially enhance the level of expertise in this important discipline at your institution. We are writing to seek your help and assistance in identifying appropriate fellows and junior faculty and to encourage them to apply for this program. This program can provide a platform for the development of physicians/faculty with an interest in motility and the ability to set up such programs.

In this program, selected candidates will spend one month at a Center of Excellence in Gastrointestinal Motility and Neurogastroenterology in order to learn firsthand the latest technologies and treatment options for gastrointestinal motility disorders, under the guidance of national experts in gastrointestinal motility and functional gastrointestinal disorders. Each participant will receive a stipend of up to \$2,500 to help cover travel and lodging expenses.

A variety of teaching activities will be employed to instruct the participants how to evaluate and care for patients with GI motility and functional gastrointestinal disorders. These include the following:

- Observe GI motility procedures and learn how to interpret the clinical tests under the supervision of faculty mentors.
- See patients with a variety of complex and challenging GI motility disorders such as achalasia, diffuse esophageal spasm, gastroparesis, functional dyspepsia, irritable bowel syndrome, constipation, intestinal pseudoobstruction, and fecal incontinence. There will be in depth discussions on treatment and management of these problems.

- Attend didactic lectures – these lectures will explain the procedures performed to evaluate GI motility disorders, the disorders themselves and their pathophysiology. Case discussions will also be used. Participants will receive a comprehensive syllabus of procedures and topics in GI motility.
- Each individual participating in the program will develop two case presentations for a conference and/or publication under the direction of a mentor. After completing the program, participants will be able to present these to their parent institution as a “local” resource of motility expertise.
- By the end of the rotation, each participant will become familiar with a wide range of gastrointestinal motility tests including esophageal manometry, esophageal pH monitoring, gastric emptying, breath testing, and anorectal manometry and how to apply this knowledge to optimally evaluate and manage patients with these disorders using current and evolving therapies.

Each year ten trainees (gastroenterology fellows or junior faculty) are selected to have the opportunity to spend a one-month training rotation at one of the five ANMS-recognized Gastrointestinal Motility Centers of Excellence: Cedars-Sinai Medical Center, Los Angeles, CA; Medical College of Wisconsin (Adult and Pediatrics), Milwaukee, WI, Northwestern University, Chicago, IL, Ohio State University (Pediatrics), Columbus, OH, Temple University, Philadelphia, PA; University of Kansas (Adult and Pediatrics), Kansas City, KS; University of Iowa, Iowa City, IA; and University of Michigan, Ann Arbor, MI, University of North Carolina at Chapel Hill, NC and Wake Forest University School of Medicine, Salem NC.

Applications are available on the web site of the American Neurogastroenterology and Motility Society: www.motilitysociety.org. Applications are considered on a rolling basis, preferably by mid-August, to be considered for a one month rotation during the months of September to June. In order to apply for this clinical training program in GI motility and neurogastroenterology, the applicant should submit the following three items:

1. Completed application form (on-line)
2. Letter of nomination from the Program Director or Chief of Gastroenterology
3. Curriculum Vitae

These three items comprising the application should be sent to the ANMS at or fax to 734-699-1136. ANMS Clinical Training Program in GI Motility, 45685 Harmony Lane, Belleville, MI 48111. Further information on this program can be obtained from the following: Satish Rao, MD, PhD. Chair, Clinical Practice and Education Committee, American Neurogastroenterology and Motility Society, Professor of Medicine, University of Iowa; Iowa City, IA, Telephone: 1-319-353-6602; Email: satish-rao@uiowa.edu. Henry Parkman, MD. President, American Neurogastroenterology and Motility Society, Professor of Medicine, Temple University; Philadelphia, PA, Telephone: 1-215-707-7579; Email: henry.parkman@temple.edu. Lori Ennis, Executive Director, American Neurogastroenterology and Motility Society, Telephone: 1-734-699-1130; Email: admin@motilitysociety.org.

**Rome Foundation Research Initiative
Request for Applications**

The Rome Foundation plans to fund investigator-initiated research grants to develop knowledge in the field of Functional Gastrointestinal Disorders. Preference will be given to applications that (a) test the validity and/or utility of the Rome III diagnostic criteria, (b) assess the epidemiology of the FGIDs, or (c) advance knowledge of outcome assessment or trial design for FGID treatment trials.

Applications will be reviewed by an independent review panel that is external to the Rome Foundation Board of Directors according to the following criteria: (a) Relevance to funding priorities. (b) Feasibility. (c) Scientific approach. (d) Experience and capacity of the investigators. Grant support of up to \$50,000 U.S. will be provided. Because the Rome Foundation is a non-profit organization, no indirect costs will be allowed.

Contingent on available funding, the Rome Foundation plans to offer these awards on a continuing basis with a deadline set for October 31.

Applications should adhere to the following guidelines:

- 1) Face page should identify the principal investigator including contact information, title of the application, institution where the work will take place, amount requested, project period, and names and signature of a business official who is authorized to accept the grant on behalf of the PI and to agree to a waiver of indirect costs.
- 2) Abstract of up to 300 words structured to provide the background, aims, and methods.
- 3) Biographical sketches of PI and co-investigators in the NIH format. These bios should include publications and other support. Biographical sketches are limited to 4 pages for each investigator.
- 4) Proposal structured as (a) Aims, (b) Background and Significance, (c) Previous work of the research team relevant to the proposal, (d) Methods, (e) Timeline, (f) Human Subjects, and (g) consortium arrangements (if relevant). Sections a-e are limited to 12 single-spaced pages in Arial or Roman 11 point font with margins of at least 1.0 inch on all sides. Each page should include the name of the PI and the page number.

For application forms or questions, please contact romefoundation@degnon.org. Applications should be submitted to: Rome Foundation, Inc., c/o Degnon Associates, Inc., 6728 Old McLean Village Drive, McLean, VA 22101, USA, Email: romefoundation@degnon.org, Fax: 703-556-8729.

The Rome Foundation publishes its *Rome Foundation Reporter*. The Rome Foundation is an independent not for profit 501(c)3 organization that provides support for activities designed to create scientific data and educational information to assist in the diagnosis and treatment of FGIDs. Its mission is to improve the lives of people with functional GI disorders. Visit their web site at www.theroamfoundation.org.

2009 is the 7th year for the Annual Functional Brain-Gut Research Group's Functional GI Disorders Young Investigators' Forum, usually taking place during the third weekend of March. The Functional Brain-Gut (FBG) Research Group is a non-profit, international organization of researchers and clinicians that supports, promotes and advances multidisciplinary research and education in the basic science, clinical and behavioral aspects of brain-gut interactions. Their official journal is *Neurogastroenterology & Motility*. The FBG Young Investigators' Forum offers a valuable and unique opportunity for GI Fellows to receive career mentoring and interact with distinguished members of faculty who are leading experts in the field of functional GI disorders. FBG covers travel and lodging expenses and provides meals during the meeting for all applicants whose abstracts are selected for presentation. Applicants are invited to submit abstracts of their basic science or clinical research in functional GI disorders. The faculty then evaluates each abstract and selects the

top 20 for oral presentation at the meeting. During the meeting, young investigators giving oral presentations of their abstracts with presentations of merit also receive a travel grant to attend Digestive Disease Week. This conference is designed to be both educational and enjoyable; faculty members provide brief didactic lectures on topics pertaining to many aspects of career development, including grant writing, developing collaborations, fostering mentoring relationships, and obtaining NIH and industry funding. They also interact directly with young fellows-investigators in small breakout sessions. For application forms, please visit the FBG website at www.fbgweb.org or contact Joyce Fried at 310-794-1958, email jfried@mednet.ucla.edu.

The University of Iowa Carver College of Medicine has conducted eleven previous symposia on Neurogastroenterology & GI Motility that has been enthusiastically received by physicians, trainees and technicians across the nation. This symposium is the most up-to-date and state-of-the-art, interactive teaching program that utilizes audience response systems, video demonstrations, workshops, and other media to teach the fundamentals and practical aspects of Neurogastroenterology and Motility. The 14th symposium is scheduled for February 13-15, 2009, at the Hilton in the Walt Disney World Resort in Orlando, Florida. Each fellowship program is encouraged to nominate one GI fellow for receiving the University of Iowa Carver College of Medicine Motility Symposia Travel Award. Through generous unrestricted grants from sponsors, a limited number of awards can be made to fellows with an interest in Motility. Thus, this opportunity is intended for the young budding mind whose aim is to become a potential leader in the subfield of GI Motility. The Travel Awards provides subsistence towards travel and registration for the course. Nominees are asked to submit a 300-word or less abstract on a basic, clinical, or translational aspect of Neurogastroenterology and Motility – representative of their research work – that will be reviewed by the planning committee, prior to making the award. The awardee then presents this research as a poster during the symposium. Applications should be submitted no later than mid-December, with awardees informed by December 31. For information about this symposium, contact Heidi Vekemans at heidi-vekemans@uiowa.edu or Dr. Satish S.C. Rao, Director of Neurogastroenterology & GI Motility at the University of Iowa, at satish-rao@uiowa.edu, phone 319-353-6602, fax 319-353-6399.

The 9th International Symposium on ‘Functional Gastrointestinal Disorders’ was held from April 9-12, 2009 at the Pfister Hotel in Milwaukee, Wisconsin, jointly sponsored by the Office of Continuing Professional Development in Medicine and Public Health of the University of Wisconsin in Madison and by the International Foundation for Functional Gastrointestinal Disorders, in cooperation with the Functional Brain-Gut Research Group, and various corporate supporters.

Participate is a quarterly publication of the International Foundation for Functional Gastrointestinal Disorders (IFFGD). IFFGD is a nonprofit education and research organization whose mission is to inform, assist, and support people affected by gastrointestinal disorders. The Web site is www.iffgd.org. Other affiliated Web sites include www.aboutibs.org and www.aboutincontinence.org. One can become a member of IFFGD and participate in surveys by contacting the organization at: PO Box 170864, Milwaukee, WI 53217-8076; phone 414-964-1799, toll free 888-964-2001. The AMS (American Motility Society) has a web site, <http://motilitysociety.org>.

For information regarding dyspepsia, visit www.dyspepsiainfo.com.

Interpreter Services

UNC Hospitals Interpreter Services has a pager number 347-1877. This number is in service 24 hours a day, seven days a week. This pager also serves as a back up to ServiceHub, the Web site used to request a Spanish interpreter. In the event of technical difficulties, the pager automatically activates as default, and an interpreter will be dispatched.

In an effort to improve the coordination of our translation requests, Interpreter Services has set up an e-mail address for written translation requests. Effective 6/29/07, any hospital areas with written translation requests should e-mail the document to the following address: transrequests@unch.unc.edu. This address is listed in the Global Outlook address list as "Translation Requests."

If you have any questions about interpretive services, please contact Ms. Myriam Peereboom at 6-4623.

Many of our teaching hospitals serve the poor and uninsured, and the patients our subspecialty residents and fellows see and treat represent multiple racial and ethnic groups. Infectious agents do not respect borders, as we have seen with the rapid international spread of SARS, the AIDS pandemic, West Nile virus, and bioterrorism with Anthrax. Currently, 25% of the trainees in US GME programs are international medical graduates. For these reasons, cultural issues are increasingly important for all of our trainees. Each of us is challenged to understand how patients' cultural attitudes and beliefs affect our diagnoses and therapies. The cross-cultural challenges US medicine faces are described in Anne Fadiman's book "The Spirit Catches You and You Fall Down." The California Endowment has made available online three publications for cultural competence education for health care professionals. To download these publications, go to http://www.calendow.org/pub/frm_pub.htm. The AMA has published the "Cultural Competence Compendium" and continues to address health care and socioeconomic disparities across the educational continuum (<http://www.ama-assn.org/go/diversity>). The June issue of Virtual Mentor, the AMA's online ethics journal for medical students and physicians, covers relevant ethical issues of caring for a diverse patient population (<http://www.virtualmentor.org>).

Newsletters

The Department of Medicine produces a weekly newsletter, <http://medicine.med.unc.edu/about/newsletter/newsletter.com>. The Health Affairs Bookstore produces a monthly newsletter; to subscribe, send an email request to habnewsletter@unc.edu. Division newsletters are now posted and archived on our website www.med.unc.edu/gi.

MedicalCrossfire.com is a web site designed and presented for the dissemination of medical information for educational purposes (email address info@medicalcrossfire.com).

MedCenterToday.com is a leading independent source of business information for academic medical center physicians (email address news@medcentertoday.com). CenterWatch.com is a monthly global source of news, directories, proprietary market research, and analysis for clinical trials professionals and patients (email address sales@centerwatch.com).

Oncology

On Monday mornings at 7:30 a.m., the multidisciplinary GI Tumor Board Conference meets to discuss pathology and radiologic results of patients with GI tumors. This is held in the radiology conference room in the basement of the Women's Hospital, with a continental breakfast provided. For more information about this conference, contact Dr. Gangarosa or Shannon Taylor of the Clinical Cancer Center at 6-9700 (fax 3-5016).

Additionally, the 8th annual symposium on "Gastrointestinal Cancers: Integrating Recent Advances into Clinical Practice," took place on Saturday, September 12, 2009, at the Ritz-Carlton Hotel in St. Louis, MO. The symposium has a distinguished faculty of national and international experts in gastroenterology, oncology, surgeons, and radiologists and is designed to be of interest to a wide range of audience, including gastroenterologists, oncologists, surgeons, primary care physicians, and internists. Gastroenterology fellows from training programs across the country are eligible to attend this conference, and 20 travel grants of \$500 each are offered to GI fellows, in addition to waiving the registration fee. To be eligible for the travel grants, fellows should submit a letter of interest and a copy of their current cv to Banke Agarwal, MD, Director of Therapeutic Endoscopy, Division of Gastroenterology & Hepatology, Saint Louis University School of Medicine, 3635 Vista Avenue, PO Box 15250, St. Louis, MO 63110-0250, or email him at agarwalb@slu.edu. This past year, requests for travel were received on or before August 10; fellows included their email addresses in their cv, and those selected for the travel grants were notified via email by August 15. Awardees were required to make their own travel and lodging arrangements and were given the grant money in the form of checks on the day of the symposium. This is a problem-based symposium dealing with common clinical case scenarios. Interested individuals are encouraged to visit www.gicancers.org, call 314-577-8764 (fax 314-577-8125), or call/email Janet Neuhaus at 314-256-3599 ext. 21270, neuhausj@slu.edu. The ASGE is a co-sponsor for this event and designates this activity for a maximum of 8.0 AMA PRA Category 1 Credits.

Generally the fourth weekend of January, beginning on Thursday and ending on Saturday, the Gastrointestinal Cancers Symposium takes place in San Francisco. This multidisciplinary meeting includes educational sessions and abstract presentations focusing on several types of gastrointestinal cancer. Leaders from oncology, gastroenterology, radiology and surgery communities participate in three general sessions over the course of three days focusing on 1) prevention, screening and diagnosis; 2) multidisciplinary management; 3) translational research, molecular therapy, and therapy of advanced disease. The American Society of Clinical Oncology (ASCO) is designed to serve as a resource for all cancer care professionals providing the latest updates, advances and resources for the prevention, diagnosis and treatment of people living with cancer. ASCO.org features a virtual meeting with more than 22,000 searchable abstracts and lectures from the ASCO annual meetings, representing the largest collection of oncology-related multimedia lectures available on the Web. To visit this site, the URL is <http://www.asco.org>. The web site for the American Association for Cancer Research (AACR) is www.aacr.org.

Following the success of the 2004 December meeting in Washington, D.C., Pentax Medical Company offers a cutting-edge course entitled 'GI Cancer and the Endoscopist', sponsored by the AGA and the JSGE (Japanese Gastrointestinal Association). In this joint effort, Pentax has set aside 30 fellowship grants to cover course registration and hotel accommodations for two nights to the first 30 fellows who register for the meeting. This past year, the course began on Friday, January 9th, 2009. Fellows are encouraged to register directly with the convention supervisor, Lauren Hass, at Lauren.Hass@pentaxmedical.com. For more information on the course and associated workshop, contact Ann Marie Connolly-Garcia, Director of Marketing, Pentax Medical Company, 102 Chestnut Ridge Road, Montvale, NJ 07645, 800-431-5880 x 2129, www.pentaxmedical.com,

annmarie.connollygarcia@pentaxmedical.com.

The National Cancer Institute's (NCI) web site for cancer prevention can be found at <http://www3.cancer.gov/prevention/cbrg/edrn>. Other related sites include <http://www.genetests.org> and <http://www.geneclinics.org>. The NCI has a Cancer Prevention Fellowship Program. If you are interested in pursuing research training in cancer prevention at the NCI in Bethesda, MD, information about this program is available at <http://cancer.gov/prevention/pob>. One may also contact Graca M. Dores, M.D., M.P.H., Associate Director of Clinical Prevention Research Training at NCI, phone 301-496-8640, fax 301-402-4863, email doresg@mail.nih.gov. Patients can visit <http://www.cancer.org>, official website of the American Cancer Society.

The Curtis & Elizabeth Anderson Cancer Institute at Memorial Health University Medical Center in Savannah, Georgia, is held annually during the first weekend of November (now in its sixth year) and brings together known experts in the field of research and treatment of esophageal, gastric, hepatobiliary, pancreas, and colorectal cancer. Two half-day morning sessions are dedicated to the elucidation of advances and challenges in the cellular and molecular progression to gastrointestinal malignancies and the therapeutic management of patients with such malignancies. This conference is designed to provide answers to questions concerning gastrointestinal cancer biology as well as in clinical management from prevention to treatment. Target audience includes local and regional GI specialists, medical oncologists, radiation oncologists, colorectal surgeons, and nurses. For questions regarding this conference, please contact Shirley Johnson at 912-350-7365 or Jennifer Ball at 912-350-8168.

In 2004 the National Cancer Institute (NCI), <http://www.cancer.gov>, awarded the UNC Lineberger Comprehensive Cancer Center a Specialized Program in Research Excellence (SPORE) grant in gastrointestinal cancers, with Dr. Joel Tepper as its principal investigator. The SPORE includes funding for a developmental research program in translational GI cancer research. The GI Cancer SPORE holds monthly open meetings; anyone interested in GI cancer research is welcome to participate. Please email Wendy Sarratt (wendy_sarratt@unc.edu), phone 6-3036, fax 6-8030, to be added to the interest group listserv and for specific meeting dates and locations. For more information about SPORE, see <http://cancer.med.unc.edu/news/2004/gispore/>. The NCI publishes a quarterly newsletter, *NCI Cancer Bulletin*, whose mission is "to eliminate the suffering and death due to cancer."

To obtain the Peutz-Jeghers Syndrome Newsletter, email Stephanie Sugars at pj4steph@aol.com. This monthly newsletter contains many resources for this and other syndromes, including Gardner syndrome (<http://health.groups.yahoo.com/group/gardnerssyndrome/>), familial adenomatous polyposis-Gardner syndrome support group (<http://listserv.acor.org/archives/fap-gs.html>), Kids with Gardners (<http://health.groups.yahoo.com/group/kidswithgardnerssyndrome/>), desmoid tumor survivors (<http://health.groups.yahoo.com/group/desmoidtumoursurvivors/>), and desmoid tumor e-community (<http://listserv.acor.org/archives/desmoid.html>). For the Latin-American Registry for Peutz-Jeghers Syndrome, email Dr. Asadur Tchekmedyan at asadur@adinet.com.uy.

Photodynamic therapy (PDT) is the ablation of high-grade dysplasia (HGD) in Barrett's esophagus (BE) for patients who do not undergo esophagectomy. A recent study has indicated that Photofrin (porfimer sodium for injection) PDT therapy in combination with omeprazole rendered complete ablation of HGD in BE in 77% patients (versus 39% with omeprazole alone) and fewer patients progressed to cancer after two-year follow up (13% versus 28% with omeprazole alone).

In January the Brody School of Medicine at East Carolina University sponsors a conference on the Photodiagnosis and Photodynamic Therapy in Oncology. For information, contact the East Carolina Office of Continuing Medical Education, phone 252-744-5208, fax 252-744-8209, www.ecu.edu/cme. The PDT program at the Leo W. Jenkins Cancer Center at ECU maintains that PDT is a valuable tool for the diagnosis and treatment of early staged cancers and palliation for advanced staged cancers of both esophageal and pulmonary processes. The Leo W. Jenkins site is nationally recognized for clinical and research applications of this newer technology. Using a multidisciplinary approach to the usage of PDT and extensive collaborations with other world recognized programs, PDT at the Leo W. Jenkins Cancer Center has had success treating and assessing many difficult oncologic problems. The yearly conference provides the latest practical information in using PDT as an evaluative and therapeutic tool by way of didactic and workshop sessions whereby world leaders in the field discuss current and future applications of PDT.

Position statements and technical review by the AGA suggest that occult positive stools be investigated, without regard to how the sample was obtained or the risk level of the patient for colorectal cancer: <http://www.guideline.gov> (National Guidelines Clearinghouse); the AGA medical position statement on the evaluation and management of occult and obscure GI bleeding can be found in *Gastroenterology* 2000 Jan; 118(1): 197-200.

The Lee Moffitt Cancer Center & Research Institute provides a quarterly newsletter, *Clinical Trials Update*. For information, contact 813-632-1355. The Institute is located at 12902 Magnolia Drive, Tampa, FL 33612-9497. The Center's web site is www.MoffittCancerCenter.org. The Moffitt Hotline, 1-888-663-3488, is a fast-track response system to answer cancer-related questions M-F 8 am – 5 pm.

The Colon Cancer Prevention Program (CCPP) is entering its fourth year as a signature component of the Neag Comprehensive Cancer Center at the University of Connecticut Health Center. CCPP has basic, translational, clinical, engineering, and social science faculty dedicated to the study of the biology and epidemiology of risks of colon cancer. Within its first year, CCPP has seen over 1000 patients, accumulating hundreds of individuals and families at increased risk for colon cancer. CCPP integrates clinical patients into a robust information and data-organizing platform that permits a wide range of investigator-driven projects. The projects are seamless with the CCPP's clinical care model and create a stimulating culture for any clinician. Within this context, CCPP utilizes a high level of endoscopic imaging technology, thereby permitting a unique capacity for translational studies of the early events in carcinogenesis. CCPP brings an array of assets to the clinical setting, which allows for a diverse mix of collaborations to occur. The most exciting clinical work occurs precisely within a dynamic and hybrid research culture. CCPP is located at 263 Farmington Avenue in Farmington, CT 06030, phone 1-860-679-4567, fax 1-860-679-1771, email CCPP@uchc.edu.

Orange County Health Department

The number for the Orange County Health Department is 968-2022 (Chapel Hill) or 245-2400 (Hillsborough).

Pathology/Lab Services

Our pathology/lab medicine services manual can be viewed at <http://www.pathology.unc.edu/labs/>. For questions regarding this site, please contact Mike Rogers at 6-8473 or mrogers@unch.unc.edu.

Pathology Review takes place on Thursdays from 7:30 a.m. to 8:30 a.m. in the pathology residents area on the third floor of the Women's and Children's Hospital. Since only one hour is devoted to pathology review, efficiency is premium, and only pertinent cases are to be brought for discussion.

In mid-April, the Department of Pathology and Laboratory Medicine (3-1476) presents an annual 'Review and Update of GI and Liver Pathology for the Practicing Surgical Pathologist' at the Kenan Center. This review covers pathology related to colon polyps, collagenous and lymphocytic colitis, Barrett's esophagus and assessment of dysplasia, drug-induced liver injury, chronic viral hepatitis and steatohepatitis. UNC presenters include Drs. Pamela Groben and John T. Woosley. This program is targeted for private practice and academic pathologists, pathology residents and fellows, and gastroenterologists and hepatologists, who would find the material covered to be of value in their daily practice. The deadline for registration is the first part of April; receipt of registration does not necessarily ensure attendance because of limited seating.

We recommend that fellows take a look at the following resource on the AGA website, created by Dr. Woosley:

<http://www.gastro.org/education-meetings/online-education/talking-powerpoint-pathology-slides>.

In mid-September, the Armed Forces Institute of Pathology (AFIP), in conjunction with the American Registry of Pathology, offers a highly popular annual gastrointestinal surgical pathology course in Bethesda, MD, followed by an annual course in hepatopathology, which addresses the interpretation of liver biopsies. The two-day course consists of a practical review of selected subjects in diagnostic and endoscopic pathology of the GI tract for pathologists, pathology residents, gastroenterologists, and gastroenterology fellows. This course is particularly helpful for GI fellows preparing for boards. In addition to lectures on neoplastic and non-neoplastic diseases of the GI tract, the course provides over ten hours of microscopy based on a unique collection of hundreds of endoscopic biopsies. At the conclusion of the course, participants should have a better grasp of endoscopic biopsy interpretation, clinical-endoscopic pathologic correlations, and up-to-date information on a variety of GI diseases and lesions such as polyps, dysplasia, Barrett's esophagus, chronic gastritis, infections, inflammatory bowel disease, lymphomas, stromal tumors, and neuroendocrine lesions.

The hepatopathology course provides a review of commonly encountered problems in diagnostic liver pathology at a level suitable for pathologists and pathology residents as well as hepatologists, gastroenterologists, and GI/hepatology fellows. Areas to be covered include hepatitis and other infectious diseases, toxic injury due to alcohol and drugs, cholestasis, developmental and metabolic liver diseases, and neoplasms. Participants have the ample opportunity for microscopic review of material drawn from over 300 cases, predominantly needle biopsies. At the end of the course, participants should have a better grasp of liver biopsy interpretation.

For more information, contact the course coordinator, Stephen Huntington, at 202-782-2637 (800-577-3749), fax 202-782-5020 (800-441-0094); email: came@afip.osd.mil, website:

<http://www.afip.org/Departments/edu/coursehtm/05gifs.htm>.

Personality Styles in Medical Practice

Below are summarized the seven personality styles described by Kahana and Bibring 30 years ago and demonstrate the variability in behavior that can occur within a given clinical situation. By understanding the patient's style of communication and his or her concomitant personality attributes, the physician can realign the interview process to optimize the physician-patient relationship, with the hope of providing greater satisfaction and an improved therapeutic alliance. These descriptions are not designed to "pigeon-hole" patients into specific diagnostic categories because doing so would limit the complexity, variability and capacity for change in an individual. These personality styles exist to varying degrees in everyone. Additionally, these styles do not necessarily represent neurotic behavior. During the stress of illness, one's behavior may seem odd, yet it may be psychologically adaptive.

1. Dependent and Demanding (Oral):

A. Patient's Style:

1. Requires special attention and care or (paradoxically) resists care;
2. Makes urgent requests;
3. Naïve expectation of limitless care;
4. With stress of illness, becomes more needy (regression).

B. Underlying Themes:

1. Unmet dependency needs;
2. Fear of abandonment.

C. Physician's Approach:

1. Satisfy needs for special attention:
 - a. regular visits;
 - b. availability by phone (paradoxical benefit);
 - c. maintain friendly interest;
 - d. make suggestions when appropriate to address patient concerns (e.g., diet modifications).
2. Do not ignore or demean patient requests for attention.
3. Set clear limits on patient demands; substitute attention in other ways: "I won't be able to attend your stress test, but I would like for you to phone me afterwards so we can talk about it."

2. Orderly and Controlled (Obsessional):

A. Patient's Style:

1. Actively seeks knowledge;
2. Meticulous and ordered in thinking and behavior;
3. Tends to collect or retain possessions;
4. Preoccupied with right and wrong; does not handle uncertainty;
5. With stress of illness: becomes more rigid and intellectual (rationalization).

B. Underlying Themes:

1. Attempts to control impulsive behaviors through logic and orderliness;
2. Cognitive rather than affective thinking and behavior ("affective isolation");
3. Struggles between compliance and rebellion.

C. Physician's Approach:

1. Maintain a cognitive style of communication: give the details and focus directly on the main points;
2. Minimize exploration ("probing") of feelings;
3. Avoid "wheel spinning"; focus down and prioritize the issues;
4. Address, but do not overemphasize, the uncertainties.

3. Dramatizing, Emotionally Involved (Hysterical):

A. Patient's Style:

1. Charming, warm, enthusiastic, but...
 2. Tearful, demanding or hostile if needs not met;
 3. Affective, often dramatic communication style (clothes, nonverbal behaviors, voice intonation);
 4. May be seductive (females: 'coy little girl', males: 'macho');
 5. Tends to relate better to a physician of the opposite sex;
 6. With stress of illness: avoids frightening situations (denial and repression) or rushes into it (counterphobic behavior).
- B. Underlying Themes:
1. Seeks intense and idealistic relationship with authority figure of opposite sex; wants special attention;
 2. May be competitive with members of the same sex;
 3. The stress of illness is perceived as an underlying defect (unattractive or unappreciated), which is denied.
- C. Physician's Approach:
1. Maintain attention and, when indicated, be complimentary;
 2. Set limits: avoid overinvolvement;
 3. Encourage patient to communicate feelings and concerns;
 4. Minimize detailing the information.
4. Long-Suffering, Self-Sacrificing (Masochistic):
- A. Patient's Style:
1. Exhibits suffering and need to sacrifice;
 2. Minimizes personal hardships with efforts to help others;
 3. Seeks sympathy from others;
 4. Unable/unwilling to communicate states of negative feeling;
- B. Underlying Themes:
1. Feels unworthy of pleasure, love or attention without suffering or sacrifice;
 2. May come from a childhood environment of abuse or deprivation;
 3. Pain and suffering – expiation of guilt.
- C. Physician's Approach:
1. Acknowledge the pain;
 2. Encourage the patient's ability to cope in the face of illness;
 3. Do not try to reassure or predict improvement;
 4. Support the patient's improvement as a means to benefit others: "I am hopeful we can get you back to where you can take care of your family again."
5. Guarded, Querulous (Paranoid):
- A. Patient's Style:
1. Suspicious;
 2. Hyperperceptive and oversensitive;
 3. Exaggerated self-righteous behaviors;
 4. Tends to blame or attack others;
 5. Stress of illness intensifies these projective behaviors.
- B. Underlying Themes:
1. Feels vulnerable, weak, defective;
 2. Fears being taken advantage of or injured;
 3. Projects self-blame onto others.
- C. Physician's Approach:
1. Remain friendly and courteous;
 2. Do not dispute, raise doubts or ignore patient's feelings;
 3. Acknowledge patient's feelings without reinforcing them: "I can understand how

you would be angry when you had to wait so long.”

4. Avoid overinvolvement or “taking sides.”

6. Superior, Self-Centered (Narcissistic):

A. Patient’s Style:

1. Projects an image of being important, powerful, knowledgeable;
2. Places a great deal of value on status;
3. May be demeaning or arrogant;
4. May “show-off.”

B. Underlying Themes:

1. Has a need to surpass others to compensate for fear of personal failure;
2. Reacts to illness as a threat to image of invulnerability;
3. Seeks out “the best” and then searches for his or her weaknesses.

C. Physician’s Approach:

1. Acknowledgement of achievements;
2. Avoid feeling and behaving as if threatened;
3. Refocus issues from a competitive to a team interaction: “I think that between the two of us we will be able to work out the best plan for your care.”

7. Uninvolved, Aloof (Schizoid):

A. Patient’s Style:

1. Gives image of remoteness and lack of involvement with everyday issues;
2. May be eccentric, unsociable or aloof;
3. May associate with “counterculture” activities;
4. May be difficult for others to follow his or her thought process.

B. Underlying Themes:

1. May have had disappointments early in life with forming close relationships;
2. Incomplete development of social skills; seeks solace within him or herself;
3. With stress of illness tends to deny underlying anxieties by becoming more detached or inappropriate.

C. Physician’s Approach:

1. Respect patient’s need to be unsociable or different;
2. Do not make demands for personal involvement with others but...
3. Encourage interaction by showing interest/attention without placing demands;
4. If medically reasonable, encourage patient to incorporate his or her ideas in the treatment plan: “I think it would be fine to modify your diet if it improves your health and well-being.”

Pharmacy Services

Pharmacy services include the Pharmacy Assistance Program at 6-0248, contact person Susie Whorley at pager 123-4921. The ACC pharmacy’s number is 6-7675 (fax 6-9311). The hospital pharmacy’s number is 6-2376 (fax 6-7757). The Neuroscience pharmacy’s number is 3-3555 (fax 6-8735). Pharmacy’s web site is <http://www.med.unc.edu/wrkunits/8hosp/pharmacy/welcome.htm>.

The UNC hospital pharmacy formulary’s web site is

<http://www.med.unc.edu/wrkunits/8hosp/pharmacy/welcome.htm>.

The Pharmacy and Therapeutics Committee has approved the following changes to the UNCH Formulary. These will take place beginning Monday, January, 2006:

****Proton Pump Inhibitors:** IV pantoprazole (Protonix) is being deleted from the Formulary and replaced with IV esomeprazole (Nexium). The two drugs are dosed the same both for intermittent and continuous infusion uses. The change will result in cost-savings as well as make our IV and PO PPI on the formulary both the same. Effective June 1, 2007, NC Medicaid requires prior authorization for use of branded PPIs, with the exception of: 1) failed omeprazole 40 mg for 30 days, 2) esophagitis Grade C, 3) esophagitis Grade D, 4) cannot swallow tablets, 5) cannot swallow capsules. If so, the exception must appear on the prescription at the bottom. Otherwise, at UNC, if a Medicaid patient goes to one of our pharmacies with a script for an Rx PPI, s/he gets an automatic therapeutic substitution to omeprazole. Outside pharmacies tend to contact the physician to ask permission for an alternative. At this point, this does not apply to Medicare patients or to other third-party payers.

****H2 Blockers:** IV and PO ranitidine (Zantac) are being deleted from the Formulary and replaced with IV and PO famotidine (Pepcid).

For inpatients: Pharmacists will convert patients beginning Monday Jan 9th from pantoprazole or ranitidine to the appropriate equivalent dose of esomeprazole or famotidine, respectively.

For outpatients: Outpatients currently receiving prescriptions for ranitidine will be converted to famotidine beginning in February when they come in for refills.

Any questions or concerns can be directed to the **UNCH Drug Information Service** 8 am - 4:30 pm M-F 966-2373 or to the pharmacist covering your unit.

Drug Interactions can be referenced at <http://reference.medscape.com/drug-interactionchecker>.

As of 3/2/11, please be advised that the FDA has put out a new drug alert about PPIs:

<http://www.fda.gov/Drugs/DrugSafety/ucm245011.htm>

“The U.S. Food and Drug Administration (FDA) is informing the public that prescription proton pump inhibitor (PPI) drugs may cause low serum magnesium levels (hypomagnesemia) if taken for prolonged periods of time (in most cases, longer than one year). In approximately one-quarter of the cases reviewed, magnesium supplementation alone did not improve low serum magnesium levels and the PPI had to be discontinued.

PPIs work by reducing the amount of acid in the stomach and are used to treat conditions such as gastroesophageal reflux disease (GERD), stomach and small intestine ulcers, and inflammation of the esophagus. In 2009, approximately 21 million patients filled PPI prescriptions at outpatient retail pharmacies in the United States. Patients who take prescription PPIs usually stay on therapy for an average of about 180 days (6 months).

Prescription PPIs include Nexium (esomeprazole magnesium), Dexilant (dexlansoprazole), Prilosec (omeprazole), Zegerid (omeprazole and sodium bicarbonate), Prevacid (lansoprazole), Protonix (pantoprazole sodium), and AcipHex (rabeprazole sodium). Vimovo is a prescription combination drug product that contains a PPI (esomeprazole magnesium and naproxen). Over-the-counter (OTC) PPIs include Prilosec OTC (omeprazole), Zegerid OTC (omeprazole and sodium bicarbonate), and Prevacid 24HR (lansoprazole).

In contrast to prescription PPIs, OTC PPIs are marketed at low doses and are only intended for a 14-day course of treatment up to 3 times per year. FDA believes that there is very little risk of hypomagnesemia when OTC PPIs are used according to the directions on the OTC label.

Low serum magnesium levels can result in serious adverse events including muscle spasm (tetany), irregular heartbeat (arrhythmias), and convulsions (seizures); however, patients do not always have these symptoms. Treatment of hypomagnesemia generally requires magnesium supplements. Treatment in patients taking a PPI and who have hypomagnesemia may also require stopping the PPI.

Healthcare professionals should consider obtaining serum magnesium levels prior to initiation of prescription PPI treatment in patients expected to be on these drugs for long periods of time, as well as patients who take PPIs with medications such as digoxin, diuretics or drugs that may cause hypomagnesemia. For patients taking digoxin, a heart medicine, this is especially important because low magnesium can increase the likelihood of serious side effects. Healthcare professionals should consider obtaining magnesium levels periodically in these patients.”

Effective 4/21/11, Lactobacillus GG (Culturelle), a probiotic agent, is no longer available from the UNC Hospitals Department of Pharmacy. The P&T Committee has removed this agent from the Formulary for the reasons outlined below:

Probiotics contain live bacilli or other viable microorganisms with the intent of altering the gut microflora of the person ingesting the product. *Cases of serious infection, including bacteremia with these organisms, have occurred and been reported in the literature.*

Immunocompromised patients and patients with indwelling catheters or devices may be most at risk. A literature search located a substantial number of published case reports of infections, including cases involving hospitalized patients who were not receiving the probiotic, but the agent was being administered to a patient in a nearby bed or room. *Therefore, it appears the risk is not just present for the patient taking the product, but also to patients located nearby or on the same unit.*

There is no evidence that probiotics prevent or treat *C. difficile* and are NOT recommended for this purpose by professional organizations. A recent American Academy of Pediatrics (AAP) review of use in pediatric patients also concluded there were few proven benefits and significant safety concerns (Pediatrics 2010 Dec; 126(6): 1217-31).

For these reasons, the P&T Committee is prohibiting use of probiotic agents of any kind in patients hospitalized at UNC Health Care. Physicians should feel free to recommend probiotic agents for patients to use at home; however, these agents must be discontinued if the patient is admitted to the hospital.

Specific drugs can be found on the web, generally by the name of the manufacturing company or by the brand name of the drug itself, for example: www.astrazeneca.com, www.axcanscandipharm.com, www.cozaar.com, www.hyzaar.com, www.merck.com, www.merckmedicus.com, www.rocheusa.com, www.zelnorm.com, www.zetia.com, www.zocor.com. The fellowship coordinator keeps a log of drug representatives associated with the GI Division. Novartis Pharmaceuticals has a corporation patient assistance program (Novartis, POB 66556, St. Louis, MO 63166-6556). Of note, patients with our state health plan can get up to a 180-day supply of a PPI

(Aciphex and Nexium with a \$25 co-pay, generic omeprazole with a \$10 co-pay) without prior authorization. After 180 days, prior authorization is required, in which case the number to call is 1-800-753-2851. Medco Pharmacy's contact information includes 1-888-327-9791, FAX 1-800-837-0959, www.medco.com.

If you call a pharmacy and leave a prescription refill message, please state your full name and leave an accessible call-back number. This is because many times a fellow does not appear in the pharmacy database, in particular if the pharmacy is not local. Please remember when calling to provide our or your own DEA number and to be clear with the date of prescription, the medication, and its form (e.g., suppository, cream). It also helps to include your UPIN # and mailing address.

For prescription pads, since the ACC and hospital pharmacies provide generic ones, if the fellow wishes to have customized ones, the fellowship coordinator can have these done through UNC printing. Otherwise, Formedic provides customized prescription pads for free of charge (toll free fax 888-633-6768, www.formedic.com). These pads look professional. However, at times Formedic may not be able to provide pads when requested because they rely on funding by drug company sponsorship. The fellowship coordinator has request forms, which can be completed and faxed to Formedic. Some of our physicians order personalized pads – also free of charge – from Medi-Scripts Services. These look professional, and there has been no problem in obtaining them. For information, call 1-800-337-3638, ext. 377 (Lili). Lili can fax a form for the physician to complete and fax back to her, 1-800-364-3209. The fellowship coordinator has blank forms on file that can be completed and faxed to her. UNC Health Care, however, encourages and prefers that care providers use our updated WebCIS, not only to create prescriptions that can be given to patients at encounters, but also to send out Rx orders. Some attendings and fellows have ordered customized pads through www.rxsecurity.com.

Some patients order drugs through www.drugstore.com. Dr. Sartor and Anthea Darling, IBD nurse, have acquired data derived from retail costs to patients ordering through drugstore.com. Several points are evident: 1) generic metronidazole is quite cheap, but the new 750 mg controlled release preparation is expensive, 2) all mesalamine preparations are expensive, while sulfasalazine is cheap, and 3) generic azathioprine is considerably cheaper than purinethol (6-MP), even after accounting for the difference in dose (1-1.5 mg/kg 6-MP versus 2-2.5 mg/kg azathioprine). Please note that these figures are taken from one of the lowest cost commercial vendors and are most likely to be considerably higher at your friendly neighborhood pharmacy. You may want to factor these costs into your prescribing practices—your patients and the economy will be better off for your prudence in prescribing practices. For information on various drugs, visit www.drugtopics.com.

Patients are able to purchase both generic and over-the-counter (OTC) versions of omeprazole (Prilosec), which has upset the \$13 billion-a-year market for proton pump inhibitors (PPIs), thus putting physicians in a difficult position. The OTC omeprazole costs about \$22 per month and the generic about \$11 per month, as opposed to \$116 per month, as previously. Thus, patients and insurers save money from these new versions. In an attempt to convince physicians to keep patients on prescription PPIs, drug makers have increased promotional efforts. Some insurers, however, send patients coupons, encouraging them to use the OTC products. PPIs are the world's largest selling class of drugs.

As of June 29, 2004, unless part of a bona fide educational program, all provision of food by drug representatives-vendors is expressly prohibited by new hospital policy. Vendors may provide food for educational programs as long as they have no say in determining the educational content.

Drug samples are to be delivered to our GI Medicine Clinic only, where they are stored in a locked cabinet. Anyone who dispenses of these must sign a check-out sheet, indicating so. It is essential that the patient's full name, medical record number, and medication lot number be fully recorded in the event of a drug recall. Sample medications are for patients only and are not present for health care providers. During a recent site visit to our clinic in 11/04, there was one instance of medication being signed out by a practitioner to himself. Charts are being checked to verify that when a physician gives a patient drug samples, it is documented in the patient's chart. The physician is required to document that a sample has been given to the patient by recording the name, strength, and dosage regimen of the sample on the appropriate clinic encounter form for insertion into the patient's medical record. Our clinic policy on this matter is located in the back of the vendor's sign-out book.

The Office of the Inspector General has published a statement indicating that activities by vendors perceived as "the purposeful inducement of business" could potentially represent a violation of federal anti-kickback statutes. Thus, any inducements from vendors are suspect, such as meals provided strictly for a social function or simply to gain access to physicians. For educational lectures where food is provided, only those involved in the educational process of fellows can attend (e.g., not spouses, significant others, friends, other staff members). Pharmaceutical companies have developed a code of conduct regarding such matters, called the PhRMA code. Their interpretation does allow for the provision of meals in association with legitimate educational activities. The AMA states, "modest meals are appropriate if they serve a genuine educational function." Gifts of textbooks and other teaching tools are not considered problematic because they are intended for the educational development of the fellows.

In addition to pharmaceutical representatives and vendors, equipment representatives and vendors are required to have an invitation before visiting our unit – this applies both to our clinic and procedure areas: cold calls are not allowed. If you invite a representative or vendor, please notify Dr. Grimm or the nurse manager in GI Procedures and Dr. Sandler or Ina Fichtner in our GI Clinic. Equipment representatives are not permitted to barge into our procedure unit to promote the selling of a new device; drug representatives are not permitted to corner you in clinic and ask whether or not you are prescribing their products.

UNC Health Care and SOM Policy on Vendor Relationships

Would pens or notepads with a product or vendor name on it influence the way you do your job? While we trust members of the School of Medicine and the staff at the Health Care System, recent studies have raised questions about the influence of these trinkets or other gifts from vendors. The Patient Protection and Affordable Care Act was signed into law March 23, 2010. The new law contains a "Physician Payment Sunshine Provision" that requires drug and medical device manufacturers to publically report gifts and payments given to physicians and teaching hospital personnel beginning in September of 2013. This Act, in addition to healthcare reform in general, has raised widespread national interest in reforming how academic medical centers interact with vendors.

Effective January 1, 2011, all faculty, staff, and students of the School of Medicine and employees of the Health Care System will be required to comply with the new policy called the "Policy on Vendor Relationships in Biomedical Research or Patient Care," adopted jointly by the Health Care System and the University for the School of Medicine.

Our policy is intended to promote the safety of patient care activities, the integrity of our institutions, and the trust of our patients, while setting up a process to report relationships that are appropriate for the patient care, academic, and research missions we support. Key elements of the policy include:

Individuals may not accept personal gifts, even of nominal value, from vendors or their representatives, including pens, notepads, or trinkets which are typically intended as marketing tools.

Individuals who have financial relationships with vendors, through employment, contracts, or investments will have to report this annually (in addition to the reporting required to get approval for external professional activities for pay), and certain information will be posted publically in order to appropriately disclose relationships to patients.

Family members of UNC employees are also prohibited from accepting gifts, meals, and marketing products from vendors. Employment, contract, and/or investment relationships between family members and vendors must be reported annually.

Vendors may continue to make gifts to the University, the Health Care System, or the Medical Foundation, but they may not make contributions directly to a department or for an event such as an educational lunch.

Individuals may not accept vendor-sponsored meals unless they are (1) served as part of a general professional conference or meeting and are included in the registration for the conference/meeting, or (2) offered or reasonably reimbursed as part of an approved external professional activity for pay.

The policy is available online at:

<http://www.med.unc.edu/www/administration/policies/vendorrelationshipsolicy>

Frequently Asked Questions (FAQs) are available online at:

<http://www.med.unc.edu/www/administration/policies/VendorRelationshipsFAQs>

The policy requires that all faculty, staff, and students of the School of Medicine and employees of the Health Care System must complete a certification form each year. The form asks that you disclose your relationships with vendors as of July 1, 2010 and forward. If you have an unmanageable conflict of interest that predates the effective date of this policy (January 1, 2011), please discuss this matter with your supervisor. Any questions may be sent to vendorrelations@unch.unc.edu.

Any educational activities sponsored by CME must comply with the ACCME Essentials and Standards. These include:

- Commercial reps cannot provide food unless in the form of an educational grant drawn up between them and our CME Office. Once a letter of agreement is signed, the company's money comes to the CME Office, and the CME Office reimburses fellows who bring food. Per CME 'Rules for Commercial Support', our CME Office charges 5% of the grant to cover administrative costs. It is advised to add this into the total expense of the grant requested instead of paying separately from division funds.
- Commercial reps can attend CME-sponsored educational activities but cannot advertise or solicit services, including the distribution of business cards. (An individual may ask a commercial rep for his or her business card, however.)

- CME disclosures must be made available to attendees at the start of each educational activity.

The **DEA #** (Drug Enforcement Administration Registration), for the dispensing of drugs, is therefore a private number that physicians prefer not to be given out unless absolutely necessary. A physician may write to the DEA to obtain a personal DEA number.

Per policy updated on 4/1/11, all physicians applying for a full NCMB license must present first with an individual DEA number. This policy can be viewed at <http://bit.ly/gcfTZm>. Residents and subspecialty residents appointed to the housestaff through the UNC Hospitals' Office of Graduate Medical Education are excluded from this policy for the time being and should continue using the institutional DEA registration for UNC Hospitals (AN-3208065). An individual DEA # must be renewed every three years at a present cost of \$551. *However, if you are an academic physician, you do not have to pay the \$551 fee. On the DEA application, there is a section to check that allows the fee to be waived. Physicians affiliated with federal or state institutions are exempt from paying fees as long as their DEA number is used solely at that particular facility. Physicians are expected to use their individual DEA, not the institutional one.* In the UNC School of Medicine, physicians must indicate either our Department Chair or Division Chief as the certifying agent and should provide the name, title, and phone number of the certifying agent. DEA will not issue an individual number until this agent has been contacted and confirms employment.

To obtain a DEA number, call or write:

Drug Enforcement Administration Registration
3420 Norman Berry Drive, Suite 302
Hapeville, GA 20254
404-763-5861 phone
404-893-7116 fax

If a physician has moved and wishes to have the address changed on his or her DEA certificate, the physician must submit a letter stating the new address from the old with copies of 1) current DEA certificate and 2) current NCMB license. This letter can be mailed to the address above or faxed to the fax number above, ATTN Ernie.

Drug registration applications can be found at www.deadiversion.usdoj.gov and requires that one have Acrobat 4.05 version. In North Carolina, one can contact Renita Hare at our regional DEA headquarters at 888-219-8689. The national DEA headquarters' address and contact information are as follows:

Drug Enforcement Registration
US Department of Justice
Central Station
POB 28083
Washington, DC 20038-8083
1-800-882-9539

Of note, the DEA has begun to clamp down in regard to narcotic refills for chronic pain and require that patients with narcotic refills must be seen every 30 days.

Smoking Cessation: The Division of Pulmonary Diseases has begun a comprehensive Smoking Cessation Program, which includes a variety of services:

- Outpatient consultation, 6-7933.
- Inpatient consultation, page Jeanie Mascarella, RN, MSN, 216-3025.
- Support groups (3rd Wednesday of the month, 7 p.m., UNC Lung Center, 3rd floor ACC.
- Online, <http://www.quitnownc.org>.
- Toll-free phone support, 1-877-448-7848.
- Healthcare provider education, krumnach@med.unc.edu.

Per the Surgeon General, a health care provider should ask every patient at each encounter if they use tobacco products and advise the patient to quit using tobacco products if such is the case. Patients who are members of the NC State Health Plan can contact the NC Quitline at 1-800-784-8669 (QUIT NOW) for counseling assistance. They can also visit www.shpnc.org and log onto their NC HealthSmart Personal Health Portal to take advantage of available online smoking cessation resources. Individuals can also visit www.mytimetoquit.com. Within UNC, individuals can contact our Nicotine Dependence Program at 3-1521 (ndp@med.unc.edu) or make an appointment with a tobacco dependence specialist by calling 6-0211.

As of July 4, 2007, use of tobacco in the hospital and surrounding UNC medical complex is prohibited. This is to encourage and promote a safer breathing environment for all patients, visitors, and health care employees. If an individual is found smoking within a tobacco-free zone, a fine of \$125 may be charged.

In accordance with our Wellness Initiative beginning in January of 2010, NC Health Smart's number is 1-800-817-7044, web site www.statehealthplan.state.nc.us. *Member Focus* is the State Health Plan's monthly e-newsletter. The SHP's web site is www.shpnc.org.

Student Health Services: James Taylor Student Health Services, CB# 7470, phone 6-2281, fax 6-0361.

Up to Date

Up to Date, a site developed by Health Sciences Library, is a comprehensive site listing informative resources such as UNCLE, Medline, MedlinePlus, alternative medicine, health and psychology instruments, in addition to current journals housed at HSL and at other UNC-CH libraries, www.hsl.unc.edu/eresources.cfm. Fellows are allowed to access Up to Date in three different locations: one in the GI Procedures Office, one in the GI Medicine Clinic, and one on a hospital floor (please inquire as to which floor). These accounts should be up and running and can be accessed by logging in the following information: Procedures: ID p7010, PW gimd; Clinic: ID c7010, PW gimd; Floor: f7010, PW gimd. It was discussed to assign one account to a first-, second-, and third-year fellow; however, this would not control simultaneous usage, which is why this arrangement is based on location. It seems reasonable that the floor account should be available for use outside of the procedures unit or clinic as this is the one least used by active clinical fellows. In this way, each ID/PW combination must be used specifically in the designated area to avoid multiple users on a single user ID at the same time. Our account in the past has been suspended as a result of this problem; consequently, we must strictly adhere to this policy to avoid this consequence in the future.

Per Health Sciences Library in 2/07, accessing Up To Date will change at the end of June, 2007. After June 30, 2007, Up To Date will continue to be available on the UNC campus, including within

the hospital and the Ambulatory Care Center (ACC). Because of excessive costs in maintenance, after June 30, 2007, there will no longer be any off-campus access to Up To Date. For example, this means no access from home, off-campus offices, or off-campus rotations.

In view of this circumscribed use of Up To Date, consider using these tools available both on and off campus:

Point-of-care resources:

Cochrane Library, <http://www3.interscience.wiley.com>
 eMedicine, <http://emedicine.com>
 FIRSTConsult, <http://www.firstconsult.com>
 MD Consult, <http://www.mdconsult.com>
 TRIP Database, the Search Engine for Evidence-Based Medicine,
<http://www.tripdatabase.com>

Textbooks and reviews:

ACP Medicine, <http://www.acpmedicine.com>
 Books@Ovid, <http://gateway.ut.ovid.com>
 eClinics, <http://www.sciencedirect.com/mdc/journals>
 Harrison's Online (Harrison's Principles of Internal Medicine),
<http://www.accessmedicine.com>
 STAT!Ref Online Medical Database, <http://online.statref.com>

For more information, refer to <http://unchsl1.depts.unc.edu/HSL/News/uptodate.cfm>. Direct any questions or comments to HSL-IRCG@listserv.unc.edu. With any problems concerning access, please direct concerns to Diane McKenzie of Health Sciences Library at 6-1776 (fax 6-1388), diane_mckenzie@unc.edu.

Web Sites

For specific GI diseases one can refer to www.colonicdiseases.com.

ePocrates DocAlerts sends care providers weekly information on various medical issues, including, as of late, IBD and colorectal cancer screening. To learn more about ePocrates DocAlerts, please visit their site at <http://www.epocrates.com/products/docalert.cfm>. In addition, ePocrates has developed an advanced version requiring a subscription of \$50, called Rx Pro. The team at ePocrates is encouraging physicians to get this paid for by pharmaceutical reps. The method of doing this is explained on the web site. Hence, the next time a drug rep offers to buy you lunch, perhaps you may mention this instead. One can also email docalerts@epocrates.com.

InfoPOEMS (Patient-Oriented Evidence That Matters) is a clinical awareness system that keeps practitioners current and answers clinical medicine questions at the point of care with accurate information. This includes daily email alerts (DailyPoems) and the InfoRetriever database application system. For more information on InfoPOEMS, please visit <http://www.infopoems.com>. WebMD (<http://www.webmd.com>) is an excellent site for patients to refer to and includes a link to Medscape and programs on weight loss, health maintenance, and fertility.

PubMed is the National Library of Medicine's (NLM) search service that provides access to over 11 million citations in MEDLINE and PreMEDLINE. If you do a "google" search and enter 'PubMed', you will be directed to a PubMed Tutorial, PubMed Medline Query, and CAM (complementary and alternative medicine) on PubMed.

TRANSCRIPTION SERVICES

Our division uses Escription, a transcription company based in California. In 6/03, Total Emed bought out EDiX, and, in the winter of 2003, Escription bought out Total Emed. Because Escription operates by a voice recognition system, our cost per line has been reduced from 17 cents per line to 12 cents per line. This, in addition to procedure path follow-up letters being done on ProVation, helps reduce the high cost of transcription services. What we aim to achieve is lowered cost of transcription services in conjunction with a higher rate of reimbursement through proper coding. Our account is subdivided into GI and Liver. Anyone on the Liver service must dictate using the codes for Liver.

In order for you to be able to receive documents on your work activity list and to sign off on them electronically, you must fill out an 'electronic signature' privilege form required by Medical Information Management (MIM). You can obtain this form from Shelly Fritts, our human resources facilitator, shelly_fritts@med.unc.edu, 6-0775. Please make sure that MIM has your correct MD code number for this process.

GI Codes

307201	attending new patient visit
307202	attending established patient visit
307901	resident new patient visit
307902	resident established patient visit
307203	teaching physician summary
307394	interim note
307380	psychologist established patient visit
307382	psychologist new patient visit
307381	psychotherapy evaluation

The 'interim note' is used to document telephone calls, prescription refills, and lab results.

Liver Codes

304201	attending new patient visit
304202	attending established patient visit
304901	resident new patient visit
304902	resident established patient visit
304203	teaching physician summary

Key Pad Instructions:

1	pause
2	resume dictation
3	5-sec rewind
4	15-sec forward
5	disconnect
6	go to end
7	15-sec rewind
8	next report
9	go to start

* mark STAT
 0 no function
 # clear STAT

To dictate multiple reports, press 8 after each report, then enter the new document type followed by the medical record number and begin dictating. After you press 8, a confirmation number will play—if you do not wish to hear the confirmation number, press 8 #, then enter the new document type and medical record number. To mark a report STAT, press the * key after step 4.

ACCESS:

Within the UNC Healthcare System, dial 3-4000. Outside the UNC Healthcare System, dial 919-843-4000. If this number is busy, use the back-up number 781-453-2120.

TO BEGIN DICTATING TO ESCRIPTION BY PHONE:

- Enter the first five digits of your provider number followed by the # sign.
- Enter the appropriate document type per above followed by the # sign.
- Enter the patient medical record number without the check digit followed by the # sign.
- Begin dictating after the tone.

Please be **clear** when dictating the following information:

- Your name
- Spelling of the patient name
- Patient's medical record number without the check digit
- Date of service (extremely important)
- Attending physician

Please be careful to include all information as correctly as possible because Escription's database matches with our SMS (appointment) database and if something is incorrect (patient name, medical record number, date of service), the document will be kicked back to Escription, thus causing a delay. Unfortunately, Joe Baker of MIM cannot correct such information—the document in error must be sent back to Escription, who then corrects it and sends it back to us. Joe must investigate to find the correct information. The date of service is **not** necessarily the date dictated; sometimes the care provider mistakes the date dictated with the date of service; what must be keyed in is the date of service.

Escription may not recognize a patient's medical record number if the patient has not checked in for his/her appointment within the last six months. If a patient has been seen prior to the last six months but missed his/her appointment, Escription will not recognize the MR number. An example of this is when a patient misses an appointment and the care provider wishes to send a letter reminding the patient of this fact; in such a case, if Escription does not recognize the MR number, the care provider can call Joe Baker of MIM who can set the system to recognize the MR number. This only takes a few minutes.

It is **mandatory** that the attending physician be stated with each document. This is not only for billing purposes and to indicate adequate supervision mandated by the Residency Review Committee (RRC), but so that the document appears on the attending's work activity list, gets signed and

signed by the proper person, and gets sent and sent to the appropriate referring/primary MD. If a document is to be autofaxed to a referring MD, only an attending can sign off on it electronically. If the attending's name does not appear, the document will never be sent. It is important to check, as well, that the proper attending's name appears on the document so that it appears on the proper attending's work activity list. When a support staff schedules a patient appointment, s/he should make sure that the attending's name is correct. Again, when the patient checks in at clinic registration for his/her appointment, the receptionist should make sure that the correct attending is indicated. This serves as a double check to ensure correct information, especially now that we must be more aware of HIPAA policy.

The check-in people in the appointment reception area must also doublecheck to make sure they know the appropriate attending for a fellow's clinic or procedure for that day so that they can update this in the system if need be. They have been asked to check our web calendar on a daily basis. Because the web calendar is updated on a regular basis, if an attending precepting a fellows' clinic or procedure must make a last-minute change or one that is too late to be posted on the web calendar, s/he should walk out to the check-in area and let the receptionists know of the change and who will be the correct attending for that particular day.

In March of 2003, our Compliance Office audited many of our clinic charts. As the clinic manager noted in terms of our division, we incurred monetary penalties for error rates of greater than 5%, for the most part due to provider ID errors caused by outpatient visits involving fellows charging in the name of one attending when a different attending had attested to involvement with the case. We must be consistent in this regard: be sure that the attending named on the charge form is the attending with whom you staff the case, who is the same one you include in your dictation.

Once the attending reviews the document, s/he has assumed that the fellow has read and edited it and is satisfied with the end product. Once the attending signs off on it electronically, it goes to the Clinical Work Station (CIS) where it is posted permanently, after which no corrections can be made. Please be careful in reviewing documents you have dictated and to make sure that the note you sign off on is indeed one you dictated. There have been instances in which, by error of CIS, notes from other fellows and attendings have appeared incorrectly on physician's work activity lists. The physician, instead of reading the note for accuracy, signs off haphazardly, and a note appears on the CIS by a physician who never dictated it. In this case, one can contact Joe Baker, who can go into the system and delete it. Several physicians have commented on receiving notes dictated by physicians in other areas; if so, you can return the note using the 'send back' option. The note will then be sent back to Medical Information Management (MIM) for resending to the correct person. You can also add an explanation in the comment section. Fellows using Escripton should check their work activity lists at least once a day, preferably at the end of the day.

In April of 2003, the Ambulatory Care Clinic Committee decided on a standard of dictating clinic notes within two weeks and having them signed electronically no later than six weeks after the patient's date of clinic visit.

In order for notes to be autofaxed to the appropriate referring care provider, the attending must make sure at the time s/he signs off that the physician name and address that appear in the pop-up box are correct. The attending can check with the content of the note to coordinate this information and to ensure accuracy. If an incorrect name or no name appears, the attending must supply the correct name or add the desired name from the care provider list. If a care provider does not appear on the list, the attending must supply and key in the necessary contact information. Once new information is keyed in, it is then added to the SMS database. However, per Carolina

Consultation Center, adding physicians to WebCIS may take up to two weeks. If a care provider needs to be added sooner, please email cccprodc@unch.unc.edu. This email account is checked every day and those who check it do their best to update information as quickly as possible.

Regarding cc's at the bottom of documents, or adding a name as a 'cc' at the bottom of the note does nothing except indicate in the note to whom the dictating physician is ccing. Again, the attending who signs and finalizes the note needs to make sure the note will be autofaxed to the appropriate care provides, to include referring and cc'd providers. Again, the physician will need to make sure to add the cc'd physician(s) if that physician is not listed in the pop-up box.

For fellows, it is better to do this after the attending has signed the note, but it can be done at anytime. In this case, go into WebCIS, bring up the patient's note, click on 'Send to Provider', and do a manual search for your cc. When you find the correct provider, click on 'send', and the note should autofax to that physician.

It is important to remember that the referring physician must be keyed in at every subsequent appointment besides the initial one for clinic notes. We have had instances where return patient clinic notes were not being sent out to the referring MD because it was assumed that once the referring MD was keyed in for the new patient clinic note all subsequent return notes would be sent to this MD; however, this is not the case. The referring MD must be keyed in each time for the return note to be sent to this MD.

In addition, remember that, as part of your work activity list, you also receive carbon-copied correspondence from care providers besides your own dictated material.

Another problem area has occurred when a care provider could see her note on the CIS but could not get to it for editing because of a 'delayed' message that has appeared. In this case, the care provider was instructed to delete the 'delayed' message, after which she was able to edit the note for electronic signature. Other care providers have referred to notes they dictated and signed off on posted on the CIS as either blank or incomplete. In this case, again the person should contact Joe Baker of MIM. It is very important that a fellow keep track of the notes s/he dictates by retaining the seven-digit confirmation number assigned to each document after dictation. Care providers have commented that some notes they dictated, for some reason, never appeared on their work activity lists, in which case, again, they had to contact Mr. Baker.

Most care providers jot the dictation confirmation number down on the green sheet, which they follow in part for that purpose. Each patient visit record sheet contains a white sheet (top page), which is to be charted in the patient's medical file, the green sheet (second page), which the care provider is supposed to keep for his/her use and/or to keep in the patient's 'shadow chart' if one is kept, and the yellow sheet (third page), which is dropped off in GI Procedures for pick up to be taken and used as part of hospital demographic statistics. Additionally, the attending, or the fellow in review with the attending, is supposed to use the triple MMR (medical management record) sheet to update both a patient's problem list and medication list. The attending, nurse, or fellow should review these lists with each patient to ensure currency and accuracy. The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) audits MMR sheets and checks for currency and accuracy. The JCAHO expects 90% compliance in this area. A care provider can use the green sheet to guide his/her dictation. In addition for use in data entry for demographic statistics, the yellow sheet can be used as a prescription at our pharmacy, where this particular data can be updated into the patient record; the yellow sheet is also used in data entry to update a patient's problem list and medication list so that this information is current and accurate on the CIS. *It is important always to take note of the EDiX document number because this is what is used to track an outstanding note; if one is not*

known, it could take weeks to find such a note, which EDiX is reluctant to do. According to MIM, there is no such thing as a ‘missing note’, just an ‘outstanding’ (delayed) one.

TO CORRECT A DOCUMENT appearing on one’s work activity list, the care provider must click on one of the three blue headers (HPI, PE, Assessment/Plan) and edit within the space between the two parameters. Whatever is outside of the blue headers cannot be edited. (Some care providers have complained that this limits them.)

Requirement for clinical fellows: Because each fellow meets one half-day clinic per week @ four weeks per month and is anticipated to see at least three new patients and four return patients per clinic, the assumption is that clinical fellows will generally see 12 new patients per month except when the clinics themselves are canceled for vacation, etc. Although ‘no shows’ and an overflow of return patients can be a problem, it is our intention to have each clinical fellow average seeing three new patients per clinic. Due to high late cancellations and no-show rates, as of Tuesday, 10/24/06, Dr. Gangarosa, our clinic director, changed our continuity clinic templates to the following: three 45-minute new slots and four 20-minute return slots, with Thursday’s clinic from 8:00 AM to noon and Friday’s clinic from 8:00 AM to 12:15 PM and 12:15 PM to 4:15 PM. If two return slots are open, this may be converted into a new patient slot. If a patient does not show for a new patient slot, if the patient is referred by a UNC physician, document this in the ‘phone message’ section of CIS and send a message to the referring provider. If the patient is referred by an outside physician, dictate a brief note using the ‘interim note’ option (Escription 307394); after signing this on your work activity list, you need to manually pull up a note from the ‘notes’ section, hit “send to provider” button, and key in which provider to send this to.

Unless a fellow becomes board eligible in gastroenterology and is granted attending privileges, attendings and *only attendings* are ever to submit a charge document with a charge. Fellows are not to fill out and/or turn in charge documents; instead, they must try and make sure the proper attending gets the form, fills it out, and returns it to the patient or to the check-out desk. They may go over this in conjunction with the attending in question, however. In addition, because of the issue of undercoding for services we have experienced in the past resulting in lowered reimbursement rates, no fellow is to code for services: the attending is responsible for this. Again, the fellow may go over this in conjunction with the attending in question.

Because our fellows are supervised or precepted by attendings, a short attending note must appear in conjunction with the fellows’ longer and more thorough, in-depth clinic note. The attending uses the template provided by Escription as one of its document types for this. The attending’s note can be an overview of the fellow’s note, citing presence in examining the patient with the fellow, findings, recommendations, and agreement-approval of what the fellow has written.

Of the 13 parameters comprising ‘Review of Systems’ (ROS), at least nine must be filled out (low coding) per requirements set forth by HCFA (Health Care Financing Administration). However, it is best to complete all 13 parameters for high/maximal coding, and it is suggested not to put ‘non-contributory’ or ‘n/c’ but rather ‘negative’ or a statement such as ‘all systems were reviewed with the patient and were found to be negative’, ‘otherwise unremarkable’, ‘negative except for...’, ‘Please see HPI and questionnaire completed by patient’, ‘negative for’, ‘Remainder of ROS negative’, or something to that effect if a parameter(s) requires this. “Noncontributory” is too broad and can mean different things and be interpreted as such by various reviewers, including coders and auditors.

For highest coding, technically all parameters of a clinic note should be completed. You may refer to ‘as stated previously in the HPI’, ‘per above’, ‘see HPI’ for the PMH if there is overlap, for

example, or the same for Medical Decision Making. Assessment and Plan can be combined and do not have to be outlined separately. Medical Information Management (MIM) has created the new and return templates in accordance with HCFA guidelines. In light of this, at least ten parameters of the ROS should be completed for a new patient note (a summary suffices for return patient notes); at least nine parameters of the PE should be completed for a new patient note (six suffice for a return patient note).

A new patient consultation must include a complete Review of Systems (ROS). Failure to do so can create potentially serious legal ramifications for the attending of record since the patient visit occurs days before the attending ever sees the fellow's dictation, whereas coding and billing occur on the day of the visit. Failure to include a ROS can therefore inadvertently result in fraudulent coding and downcoding. The only way to prevent this is to ensure that all clinic notes contain a ROS appropriate to the level of care. *This means a complete ROS for all new visits.*

The History of Present Illness (HPI) and Review of Systems (ROS) are the two areas most commonly missed leading to downcoding of clinic notes.

- HPI requires at least four (4) components for levels 3, 4, and 5 (new patient visit & consult) and levels 4 and 5 (established patient visit). Medical students can provide only a ROS and PFSH (past family and social history). Acceptable for HPI requirements: Criteria is met if three (3) or more chronic diseases are reviewed.
- PMFSH (past medical, family and social history) requires *all three* documented for levels 4 and 5 (new patient visit & consult) and level 5 (established patient visit).
- ROS requires at least ten (10) components for levels 4 and 5 (new patient visit and consult). Acceptable for ROS requirements: Listing all pertinent positives and negatives. "All other ROS negative" is sufficient documentation for normal findings related to unaffected areas or asymptomatic organ systems. When ROS is unobtainable, this can be indicated and its reason in the note, which meets the requirements for ROS if documented.

Dr. Lisa Gangarosa, our former GI Medicine Clinic Director, has created a History and Physical (H & P) form for you to use on all new patients you see in clinic. It is mandatory that you use this form as a guideline for proper coding. You should photocopy this and give it to the preceptor. After discussion, you should decide together on an appropriate level of billing. You can then use your copy to follow for dictation. These forms are located in the GI Medicine Clinic. If you have to see patients in the ACC, you will have to come over to the main clinic to take forms back over there, or take one form and make photocopies for yourself and your preceptor.

In addition, Tina Blanton, our GI coding specialist, attended a coding seminar during which she was given Evaluation and Management (E & M) physician dictation templates. She has provided copies for you and our attendings. This should help document consults and outpatient visits. It is hoped you will follow these guidelines for proper coding since, in the past, in regard to ROS and past/family/social history, our charges have tended to be downcoded because of incomplete or insufficient documentation of these required fields.

We want to make sure that what you dictate is commensurate with the level of service we provide to the patient so that our reimbursement rate is accurate and as high as it should be. Covering certain areas to ensure a higher level of coding does not mean verbosity: an area can be covered in fewer words and still contain pertinent information. For areas like the ROS and the Physical Exam, complete sentences are not necessary. In an attempt to generate more revenue while cutting down

on transcription costs, please do not “pad” texts, meaning, do not repeat what is already indicated on the template (such as HEART: The heart revealed a normal sinus 1 and 2 rhythm, which could be stated merely as HEART: normal S1, S2.) This also means to make sure words are not redundant and that content does not overlap in an obvious way.

One faculty member has reviewed extensive clinic notes dictated by our fellows and came up with the following examples for inclusion in this manual:

It is not necessary to start multiple sentences in the History with “The patient...” or “The patient states...” You can use “He” or “She.” If you are writing the History, it is assumed that the patient said it unless you state otherwise. Instead of “The patient reports that over the past...” why not just “Over the past...”? Instead of “The patient states that she has had less...” why not “She has had less...?” Instead of “The patient does also have a prescription for...” why not “She has had a prescription for...?” Instead of “The patient was advised...” why not “She was advised...”? Avoid “did” and “do” when they are not necessary. Instead of “The patient did have...” why not “She had...”? Instead of “We do plan...” why not “We plan...”?

Complete sentences are not necessary if the information can be clearly conveyed otherwise. In the Social History, instead of “The patient currently lives in Dunn NC alone. The patient states that his parents do live nearby” why not “Lives alone near his parents”?

Definition of a ‘new’ patient: Per AGA, a ‘new’ patient has been seen by *any member* of our division within the last three years—the patient does not have to see the same physician. If the patient has not been seen in our clinic prior to three years, then s/he is considered a ‘new’ patient.

An outpatient consult can be billed if an evaluation-opinion was requested by another physician. It is sufficient to note in the record that the patient was seen and evaluated at the request of MD so-and-so. This MD must be sent a note summarizing the evaluation-opinion. Do not use the word ‘referred’ to designate this MD but rather ‘requested’. (Do not say, “The patient was referred by...” but rather “So-and-so MD has requested...” or “So-and-so patient is being evaluated at the request of so-and-so MD.”)

Per Medicare rules, if a patient has been seen by anyone in our group within three years – including procedures – that patient is considered an established patient. However, a consultation for a specific question can be done at any time, even within the group, for example, from one specialty clinic to another (e.g., IBS to IBD), or from GI to our Liver Program (e.g., reflux, and the patient was discovered to have liver disease). In such cases, the request for an opinion can be billed as a consultation.

It has come to our attention that some of our UNC primary care colleagues are upset that our schedulers refuse to schedule patients without a “question posed.” We must require a reason for a patient visit. The internal UNC has choices of consultation or transfer of care for problem. If the latter is checked, and if the patient is a Medicare patient and has not been seen by anyone in our GI group the last three years, then they are considered a new patient (and not a consultation). As for an inpatient consult, a note should be placed in the hospital record to the effect of “GI consult requested.” If a patient requests a procedure, s/he must see his/her physician first, who will make the referral, if necessary, to our Procedures Unit. At times patients call and wish to have a procedure scheduled directly without consulting their physicians. Similarly, the clinic does not accept self-referred patients, but such patients must be scheduled through one of our GI physicians. *Because of issues of undercoding for services in the past due to the absence of daily inpatient progress notes as well as*

illegible consult notes, the fellows are encouraged and reminded to do progress notes on a daily basis. Per reports from the AMA and Medicare – and they have tailored their documentation guidelines based on these reports – many insurance carriers, including Medicare, have not been pleased with physician documentation because of illegible handwriting. To this end, we now have electronic consult notes in place so that the issue of illegibility is no longer a major concern.

To avoid this potential conflict, consult notes are now done on the WebCIS, to which Tina Blanton has access so that she can view consult notes (as well as endoscopy reports). Tina receives a daily report with the physician codes so that she can view them. When a fellow does one, it will state this on the report. When the attending signs, she will receive another report to this effect. Additionally, the program allows one to ‘cut and paste’ part of a daily progress note from the day before if information is duplicate or does not change, as long as there is a new daily note with an update of progress for that day. In addition, try to avoid a delay (e.g., five days) in doing an addendum because what appears on the note should be what is in the medical chart. You no longer need to ‘cc’ the initial consult and follow-up notes in WebCIS to Tina or to her assistant (Rebekah Gessner), as she obtains a workfile with all of the information needed to bill the charge.

When documenting daily progress notes, each note stands on its own and must include a diagnosis and any other diagnosis(es) being treated on that particular day. Per coding guidelines, “Each record or date of service must stand on its own.” The insurance company will question or deny any claim without a clear primary diagnosis appearing on each daily note. Many do well at indicating tests performed and their results and current-future treatment. However, most write in their follow-up notes the impression/plan without indicating a diagnosis. Since the attending is required to agree with the resident’s plan and assessment, s/he may fail to remember to indicate a diagnosis. Please remember to indicate a reason why the patient was initially seen as a consult, for example, “Patient with bleeding...feels better, test results negative, continue on current course of therapy, start patient on Aldactone.” In this way, no one has to look elsewhere for a diagnosis and the claim can be paid in a timely manner.

In addition, and for example, the primary diagnosis code for ESLD (572.8) is okay to use; however, reimbursement is greater if the actual reason for the ESLD is billed as the primary diagnosis, such as ESLD as a result of cirrhosis or HCV. Abnormal studies can also be an indication for a reason for a study or visit; for example, in screening for varices, it is okay to use a radiographic abnormality as the reason for the study because many of these patients present with an abnormal-appearing liver on radiology studies. In this case, the coder can use ‘abnormal GI radiology study’ diagnosis code 793.4. Initial consult notes must contain a ‘Chief Complaint’. Per consultation requirements, a ‘Chief Complaint’ is required in order to bill accurately. Medicare requires this as part of their guidelines, and so we need to have this documented correctly. For initial consult notes, the ‘History of Present Illness’ requires four elements in order to qualify for a level 3, 4 or 5 History. Without these four elements, the billable level is downcoded to a level 2. These elements should include the location, duration, timing, severity, quality, context, modifying factors, and associated signs/symptoms of the reason why the physician sees the patient. The HPI is a chronological description of the patient’s present illness from the first sign and/or symptom to the present. Documenting multiple histories of other illness is okay if it pertains to the current problem. Often physicians include documentation of numerous past illnesses that have no relation to the current problem without providing adequate or detailed descriptive factors pertaining to the current problem. Physicians often assume that, the more they write guarantees a higher level of coding, which is not the case. For example, “Management of ESLD” does not contain a description of the reason for the management of ESLD. Instead, a more detailed example is, “RUQ, intermittent abdominal pain resulting in the need for management of his or her ESLD.” Another example is if

the patient has abdominal pain and bleeding, in keeping with the aforementioned modifying elements, the location, duration and intensity of the abdominal pain should be documented, as well as the duration, pattern, quantity, and nature of the bleeding.

Other Issues Pertaining to Consult Notes

- The note must always contain the patient's full name and medical record number, including the check digit. The physician must sign his name, title (MD), and MD code number. In this way, full names are designated for both the patient and physician, with their respective institutional ID numbers. *The correct full name of the referring practitioner must accompany each note.*
- A medical student can perform and document two parameters: 1) Past Medical History, including Social and Family History and 2) Review of Systems. A medical student cannot perform a physical exam. The fellow must attest to a medical student, just as the attending must attest to a fellow. If the medical student documents the physical exam on behalf of the fellow, the fellow must attest, "I performed the physical exam and assessment and agree with the medical student (MS) documentation as above." The fellow cannot state "I agree with the history and physical exam as above" because this implies that the MS performed the exam and not the fellow. It must be clear that the fellow and not the MS performed the PE. The resident must perform the History of Present Illness, Physical Exam, and Assessment/Plan portions of the consult and follow-up notes when seeing a patient with a medical student. Merely indicating "I agree with the HPI/PE/A-P per MSIV" is not valid, and merely signing beside the medical student's name is not valid. Again, the only parameters a MS can perform are the PMSF and ROS portions of the consult. The resident must perform the HPI, PE, and A-P. If residents do not indicate their participation in these required portions of consult documentation, it results in significant downcoding of the consult. If the MS writes everything down for the resident, again the resident must make clear the fact s/he performed the necessary parameters, "I have seen and examined the patient and agree with the MS documentation" or "I have seen and examined the patient with the MS and agree with his or her documentation" or "I have seen and examined the patient with the MS and reviewed his or her documentation, to which I agree."
- Always indicate Review of Systems by checking the boxes for the ROS on the consult forms and writing the ROS under the section "Pertinent Negatives and Positives." In order to be coded for a higher level of billing, at least ten (10) Review of Systems must be checked, one from each area listed within the check box. Generally this averages between 5-7 ROS, which results in a lower level of coding for billing. Additionally, if you have a very sick or complex patient for which you have documented extensive tests, without a complete ROS, the level is downcoded because the ROS must match the severity of the possible diagnosis. The coder has shown the fellowship coordinator as well instances in which no ROS appeared at all. In four out of five consults, only one ROS was completed. For the ROS as well as the other portions of the consult such as Past Family and Social History, "n/c" for non-contributory is not valid.
- Please remember in particular to complete the 'Past Family History' portion of the consult form – the coder has seen many notes where this parameter is left blank or "n/c" is designated per above. Again, this portion must be completed, and designating "n/c" is not valid. Medicare does not recognize "non-contributory" or "n/c" when used for the family portion of the history. If this is used, due to coding rules requiring that all of the history elements are met, this will result in downcoding to a level 3.
- Attendings and fellows, please remember to review thoroughly all notes made out by hospital residents, especially new or newer residents. Our coder has seen an increase in the lack of documentation on consults from some of these residents, which has resulted in a

number of consults downcoded to a level 3 (99253). The majority of documentation issues involve skipping the PFSH tab as well as the ROS tab. Also, for the ROS, the coder has seen ‘see HPI’. The HPI does not always contain all of the necessary requirements for a complete ROS. To obtain a higher level of billing, all three parameters must be complete: HPI, ROS, PFSH. The HPI cannot be used in place of the ROS, and “n/c” or “non-contributory” cannot be used to substantiate PFSH.

- Please complete all consult notes as soon as you can, at least by the end of the week. Holding them for 2-3 weeks only delays the billing process. It is of the utmost importance that we maintain excellent intercommunication with those physicians who kindly refer us patients within the hospital. Therefore, consult notes should be completed promptly and placed in CIS where they can be read. This provides optimal continuity of care for the inpatient. If you are not completely satisfied with the manner in which the patient is cared for by housestaff, you can use this as a teaching opportunity. Given they do not have our experience, they require our assistance, which is why they request a consult in the first place. We should place priority on preserving the collegial relationships essential to providing medical care of the highest quality, and, in the process, look for opportunities to teach our housestaff.

To ensure proper billing for clinic notes, an attending must either do a ‘teaching physician’ note (new or return) or make an addendum to an existing fellow’s note (new or return) when reviewing it for electronic signature. This note should consist of a summary of the fellows’ note, which is generally in-depth and contains more information. A freestanding ‘teaching physician’ note should accompany a fellow’s note. If an attending wishes to add a summary to a fellow’s note, here are a few examples:

- So-and-so is a 46-year-old female with a diagnosis of hepatitis C and a history of, but is no longer using, alcohol. MRI was negative. At present there is a mild elevation of her transaminases. I agree with the assessment and plan provided by Dr. so-and-so. Ms. so-and-so will be enrolled in a trial of interferon.
- Patient seen, examined and discussed with Dr. so-and-so. Patient is a 48 y/o male referred by Dr. so-and-so. Patient has ESRD dialysis, abdominal pain, and a hx of NSAID-induced GUs. PE: epigastric tenderness. Plan: D/c NSAIDs, increase PPIs. No further dx work up at this time.
- Patient seen, examined and discussed with Dr. so-and-so. Patient is a 66 y/o woman with chronic diarrhea referred by Dr. so-and-so. PE: normal abdominal exam. Dx includes collagenous colitis and microscopic colitis. Plan includes colonoscopy.
- Patient seen, examined and discussed with Dr. so-and-so. Patient is a 39 y/o male with IBS and DM referred by Dr. so-and-so. PE: normal abdominal exam. Plan is to adjust meds. No further work up indicated. ADDENDUM: PT EMAILED. IMPROVED BUT W/INTERMITTENT SHARP PAINS, LOCALIZED, RESOLVING W/O BRBPR. WILL FOLLOW.
- Patient seen, examined and discussed with Dr. so-and-so. Patient is a 20 y/o male with DM, abdominal pain, and loose stools referred by Dr. so-and-so. Dx includes IBS, bacterial overgrowth, and lactose intolerance. Plan for dx testing, per above.

One notices that all of the above addenda to fellows’ notes include the standard phrase ‘Patient seen, examined and discussed with Dr. so-and-so’ (the appropriate fellow) followed by a brief description of the patient, the referral MD, diagnosis, PE, and plan.

A fellow may choose to add in his/her note a statement such as, “This hx and PE has been discussed with Dr. so-and-so (the appropriate attending), who met and examined the patient and agrees with the therapeutic plan.”

By its summary, a ‘teaching physician’ note should include the patient’s diagnosis, medical decision making, agreement with the treatment plan drawn up by the fellow, and the patient’s immediate treatment plan. The attending may wish to add statements such as

- I was present during the key portions of the service.
- I concur with the fellow’s note.
- Fellow’s note is available for further detail.

An attending must sign this type of care provider’s note in addition to the care provider him/herself. One must remember not to serve as a patient’s primary care physician because in essence we are a specialty area treating GI-related problems. All patients should have a primary care physician even though some may wish otherwise. As a general rule, we encourage faculty and fellows to act as consultants (they see the patient once or twice in clinic and refer the patient back to his or her referring or primary M.D.). In this way, the primary M.D. does not feel that UNC is “usurping” his or her patient, and it helps prevent an overflow of return patients so that we can see more new patients/consultations. Sometimes, however, a primary M.D. may not desire to have a difficult patient referred back (e.g., IBS) or one with a difficult case to manage (e.g., IBD, cirrhosis). We wish for our fellows to treat a broad patient caseload while doing their clinical training with us so that they are exposed to the various dimensions of GI-related conditions. A fellow should probably have no more than 50 patients on a regular basis. New patient visits necessitate diagnostic skills (evaluation), whereas established or return patient visits necessitate follow-up or therapeutic skills (management).

Consequently, it is important for a fellow to be fairly aggressive about returning patients to their respective referring or primary M.D. so that his/her clinic will not be overwhelmed with a disproportionate number of return patients, of whom many probably constitute difficult patients the primary M.D. is eager to let go and have us follow. This, however, potentially diminishes the number of new patient referrals we can accommodate.

The Centers for Medicare and Medicaid Services (CMS) define medical doctors in training as those with an MD degree who are either interns, residents, or subspecialty residents (fellows). Documentation created by a medical student or non-MD practitioner (nurse practitioners, RN’s, PA’s) cannot be used to support a teaching physician’s note in the same way as a resident. The Chief Complaint, History of Presenting Illness, Physician Exam and Medical Decision-Making must be performed (or repeated) and documented (or attested) by the teaching physician. Only the Review of Systems and Past Medical, Family and Social History (three components – or ‘Family’ and ‘Social’ History as two components of ‘Past Medical History’) can be documented by a non-MD and referenced by the teaching physician to support documentation for billing. Additionally, a teaching physician cannot bill for procedures performed by non-MDs (i.e., medical student, nurse practitioner). The teaching physician must either personally perform the procedure or supervise a resident in order to bill for the service or procedure.

In November 2002, CMS revised its documentation requirements to clearly state that teaching physicians do not need to repeat documentation already provided by a resident for E & M services. The teaching physician presence and participation requirements have not changed in that services provided in a teaching setting are payable under the physician fee schedule only if 1) the services are

personally furnished by the teaching physician or 2) the services are furnished by a resident in the presence of a teaching physician. The revised E & M documentation guidelines allow the composite teaching physician and resident note to serve as documentation of the level of service billed. For purposes of billing, it is not necessary for the teaching physician to comment on his or her participation in each evaluation and management component (History, Physical Examination, and Medical Decision-Making), nor does the physician have to repeat the resident's note.

The term 'teaching physician' represents instances in which the attending physician renders or supervises care of his patient involving residents.

"Incident To" Requirements: "Incident To" applies to all health care providers other than physicians (or non-MDs). For new patients or consultations, for instance, an nurse practitioner cannot perform any of the service other than the ROS and PFSH. The billing physician must perform the remainder of the history, entire physical exam, and the medical decision-making and document the service personally, either in writing or by dictation. Having the NP do even a small portion of the exam and dictate the note is not acceptable. The physician would have to repeat everything the NP does in order to bill for the entire service. In order to bill "incident to" for subsequent visits, the initial evaluation and development of the treatment plan must be services provided by the physician. A service provided by the physician is dictated by the physician. After that, a non-physician practitioner may provide "incidental" services in support of the treatment plan that are billable in the physician's name: this is actually the basic definition of "incident to."

Improving inpatient documentation (Brian P. Goldstein, M.D., 6/25/10)

One of our institutional goals for fiscal/academic year 2011 and beyond is to improve documentation of the care we provide to our inpatients. This does not mean that our past and current documentation is bad. For most of our inpatient services, because of the diligence and the skill of our residents and our attendings, our *traditional* documentation is good. However, for better or worse our care, and thus our Health Care System, is increasingly judged based solely or primarily on the alphanumeric "codes" that we assign once a patient is discharged. And it is our documentation – literally -- that generates those codes. We all know how sick and how complicated our patients are, and how well we care for our complex inpatient population. Yet unless we document accurately and completely, the outside world will not appreciate this, and payors will start to penalize us based on faulty assumptions of inadequate care. We need to re-learn, and to change, how we document our inpatient work.

"Traditional" documentation refers to documenting inpatient care for the purpose of communicating with other physicians and staff who are also caring for the patient during that current hospitalization. Documentation has also always been about making sure whoever cares for the patient in the future knows what we did today. These things are as essential to outstanding care as they have always been, and alone are enough to justify a focus on improving how we record what we do for patients. More recently, we have worked on documenting to make sure that both the physicians and the Hospitals are being appropriately compensated for your work. Documentation is also, of course, a key element of our obligation to teach our residents and medical students; our learners should learn how to document inpatient care in a way that is good for their patients and for their practice.

The use of ICD-9 and similar "diagnosis" codes to judge and infer the quality of care is new, but growing. Beginning in 2012 Medicare will use codes to track risk-adjusted readmission rates, and will penalize hospitals with the highest rates of readmissions after heart failure, pneumonia, and

myocardial infarction (with plans to add other illnesses later). Many of the groups that rank hospitals – most especially *U.S. News and World Report*, but also *HealthGrades*, *Solucient*, *The Leapfrog Group*, and *Consumer Reports* – have started to pass judgment on the quality of clinical care using hospitals' coding data. Within our profession, the University HealthSystem Consortium has its own methodology for benchmarking quality metrics using coding data. The trend is here to stay, and our residents will surely have to adhere to documentation standards once they enter independent practice.

There are a few key documentation principles that drive accurate and complete documentation. They are:

1. Document whenever possible diagnoses and not just symptoms.
2. When you document a symptom or diagnosis be as specific as possible. For example, instead of “renal failure”, document “chronic kidney disease, stage IV”.
3. Each time you rotate to an inpatient service, learn and use the key diagnoses and co-morbid conditions that you are most likely to document for patients you are caring for.
4. Respond immediately to any “coding query” that comes from a coder or documentation specialist.
5. For every diagnosis or condition, document whether that condition is (a) part of the progression or the natural history of the patient's illness, (b) an expected complication of treatment, or (c) an unexpected complication.

Every faculty member should adhere to these principles, and to include, as part of inpatient teaching, discussion and reinforcement of these principles.

In addition to promoting these principles, we are responding to the need to improve documentation in several ways. Dr. Robert Berger and his staff in ISD, along with the Inpatient Physician Service Leaders and Medical Information Management, are working together to create service-specific lists of diagnoses and comorbid conditions. Our goal is that by the end of 2010 we will embed the lists in our History and Physical, SOAP Progress Note, and Discharge Summary, so that the clinician can create a patient's inpatient problem list simply by selecting the appropriate diagnoses and comorbid conditions, and then adding (free-text) any that were not on the list. In the interim, ISD is creating service-specific inpatient lists as part of WebCIS' existing “MyDx” function. Beginning July 1 (or sooner), each clinician will be able to “subscribe” to a diagnosis/comorbid conditions list for a specific inpatient service; once subscribed, the clinician will for any patient note be able to choose from the list and bring the choices into the note. In addition, during this coming academic year, the Inpatient Physician Service Leaders will, at every change in resident rotations, meet with the incoming residents, review the importance of accurate and complete inpatient documentation, and go over the service-specific list with an expectation that the residents will use the list.

The Clinical Documentation Committee (CDC), led by Dr. Donald Spencer, has meanwhile been actively supporting other efforts to improve documentation. Within the past few months the CDC has recommended, and the Medical Staff Executive Committee has added to the Medical Staff Rules and Regulations, the following changes to our documentation standards:

1. Each inpatient will have a written daily progress note every day (other than H & P on the day of arrival and discharge summary on the day of departure). This is effective July 1st; however, in recognition of short advance notice, some services may need time to adapt. When a resident(s) is involved in the patient's care, the Rules do NOT require that the attending physician see the patient every day and write the note or the teaching physician attestation. However, the usual Medicare Compliance regulations have not changed, so billing for the teaching physician's work (unless you are within a global billing period) still requires an attending note or attestation. If you have questions about billing, please contact the School of Medicine Compliance Office at 3-8638.
2. All inpatient notes – H & P, daily progress note, discharge summary -- will be electronic. Any inpatient service still using paper should convert as soon as possible, but no later than December 31, 2010.

We understand this represents yet more change in an already dynamic practice environment. As with the new note templates, we will continue to try to make available tools that reduce the disruption that change inevitably brings. On balance, the improvements we all make in documentation will be good for our patients and good for the organization.

Coding Updates as of October 1, 2008

Please be mindful of what Medicare looks for in particular:

- visits billed with a diagnosis of anemia or elevated liver enzymes;
- any type of consultation;
- level 5 visits without an additional diagnosis(es) to support the level of complexity/ decision-making, such as comorbidities;
- screening colonoscopies with a diagnosis of family history of intestinal cancer

Some ICD-9 codes Medicare has looked at include 285.9 (anemia), 280.9 (Fe anemia), and 280.1 (Fe anemia due to blood loss). Unspecified anemia (285.9) is gradually being phased out because Medicare requires more specific documentation for the exact type of anemia being treated. Currently they do not pay for unspecified anemia, although they see it documented frequently.

Rectal bleeding is another code that Medicare is looking at because it is not the same as GI bleeding. The other bleeding codes, including melena (578.1), CGE (578.0), and unspecified (578.9) are generally high complex diagnoses that need to be treated. Because rectal bleeding is so site specific, a colonoscopy claim for this is generally denied when the descriptor indicates that the bleeding is coming from the rectal area, given that it is not medically necessary to perform a full colonoscopy when rectal bleeding is indicated.

Among billing professionals, there has been some discussion about the coding of and reimbursement for diarrhea (787.91), as opposed to functional diarrhea (564.5). Functional diarrhea is also considered chronic diarrhea. Many physicians refrain from using functional diarrhea and use the general diarrhea code. In many instances, Medicare and other carriers do not cover diarrhea (787.91) if it has not been ongoing for at least five days. Therefore, always make sure to document the *extent* of the diarrhea, as well as its complications.

An EGD is separately billable if performed with a Maloney (43450) or bougie dilator (43453). If a wireless capsule is placed during an EGD, both are billable. However, the capsule reading should be billed with a modifier 52, since some of the stomach and/or intestine was viewed via EGD.

In regard to consults, if a patient is referred from another physician *specifically for a procedure*, then outpatient surgery is all the service you are considered to be giving to the patient. Therefore, NO consult is billable. If you know before seeing a patient that you will be performing a procedure, a consult is not billable. This is usually shown as something to the effect, “referred by Dr. so-and-so for a colonoscopy” or “asked to perform an EGD for varices.” Remember that a procedure must be performed AS A RESULT of a consult. If a consult is to be billed, therefore, it must *precede* the procedure, which must be stated as such: “pt being referred for an evaluation of such-and-such to see if they need an endoscopy to be performed,” “possible EGD for dysphagia,” “GI bleeding, possible colonoscopy.” Similarly, for example, in terms of PEG placement, according to guidelines, a consult initiated “for a PEG placement” is considered to be part of the PEG itself because the documentation assumes that you already know that you will be performing the PEG placement, and therefore the consult is considered part of the procedure. However, if you are ‘evaluating’ a patient for a ‘possible’ PEG placement, then a consult to evaluate the patient is billable and payable. That is why one must be very careful with regard to wording. To use a coding phrase, “a consult is billable if a procedure is ordered as a result of the consult. A consult is not billable if the consult is a result of an already ordered procedure.”

New ICD-9 codes that affect GI as of 10/1/08 include: dysphagia 787.20 (dysphagia, unspecified), 787.21 (dysphagia, oral phase), 787.22 (dysphagia, oropharyngeal phase), 787.23 (dysphagia, pharyngeal phase), 787.24 (dysphagia, pharyngoesophageal phase), 787.29 (other dysphagia), 789.51 (malignant ascites), 789.59 (other ascites). In the coming years (later in 2008 and then in 2009), Medicare and the AMA plan to establish a screening EGD code and develop specific policies for the use of bariatric surgery, varices and Barrett’s esophagus.

IF YOU NEED TO GET IN TOUCH WITH MEDICAL INFORMATION MANAGEMENT, please email or call Joe Baker at JBaker@unch.unc.edu, 6-2525. MIM and Mr. Baker have requested that, for any problems with Escription, we contact Mr. Baker and not Escription. Thus, for any problems you may have with Escription or with your work activity list on the CIS, please request assistance from Mr. Baker.

PROVATION

Per division protocol, a copy of each procedure letter is to go to the patient unless otherwise specified by the care provider in the event of sensitive information that the care provider wishes to convey or has conveyed verbally (e.g., terminal cancer). **Procedure letters are never sent to prisoners but to the physician/medical division of the institution where they are housed.** In the past, the prison system has contacted us about letters somehow falling into the hands of prisoners because they were addressed directly to the individual (it seems as though all of this should be screened). Letters for prisoners should be addressed specifically to an MD of the prison system or to the ATTN of the medical division of the correctional facility housing the prisoner. ProVation (upgrade from Provalent to ProVation 3.5 in 8/03, with a major upgrade in 12/04) is our new GI procedure reporting system, located in the fellows’ space (B027 in GI Procedures). If you have any questions pertaining to its use, please contact Dr. Ian Grimm (isg@med.unc.edu, 6-0262). In 2/05, ProVation became a web-based program, called Citrix. All computers located in GI Procedures at UNC and Meadowmont are locally linked to ProVation, which means that you do not need to log on to Citrix if you are in the procedure area. There should be a ProVation icon on all of these machines, including the physician’s workroom at Meadowmont. Otherwise, the Citrix server can be accessed from any computer in the world. In order to gain access, however, one must be issued a personal ID user name and password, which can be done by calling hospital Information Systems Development (ISD) Customer Support Center at 6-5647. If you are outside the hospital

firewall, the URL for the server is <https://csg.unch.unc.edu/Citrix/>. If you are within the hospital firewall, the URL is <http://csg.unch.unc.edu/Citrix/>. (The 's' in the former domain is necessary for security.) With Citrix, fellows can now print out their own procedure log reports. Previously, attendings had to do this for them.

For endoscopies performed at Meadowmont, it has been reported that, even though the type of scope is selected on the screen, the serial number may not come through on the note in ProVation, in which case physicians must enter this manually. (This should otherwise be automatic.) In any event, make sure that this information is actually selected and not inadvertently omitted by reviewing the note carefully before finalizing it.

The ProVation upgrade to Citrix is supposed to fax reports to the referring MD. If you encounter a situation in which a referring physician's name does not appear, please notify Nia Riggsbee and email Dr. Grimm the physician's name so that this information can be entered into the ProVation system. If the report is delayed in being signed for 24 hours, this may give enough time to enter the physician information into ProVation so that they can receive a fax. ProVation has recently been altered to accommodate up to three electronic copies from an endoscopy report. These three names, however, must appear in the "referring" field and not in the "cc" field. Individuals appearing in the "cc" field are not faxed, and no reports are faxed to patients, which must be mailed out.

Of note, faculty need to append electronic signatures to procedure reports on ProVation *within 48 hours* of the report entry. An attending can bring up a list of all of the procedures listed by his or her name and sort them by date. These must be signed within 48 hours. Any modifications to the original report supercede the original report on the CIS up until the 48-hour lockout time.

CLO test results appear as an addendum to the EGD report. Dr. Scarlett inserts the addendum and finalizes it, for which she has been given permission. (Otherwise, the attending whose name appears on the report would have to go back and finalize the addendum before it appears on the CIS.) Additionally, CLO test results continue to be recorded in a red book kept in the GI scheduling office (reception area) with the logging of patients followed by the date of testing, the physician who performed the test, and positive or negative test results. The inclusion of the physician in this log was decided to make tracking your patients easier. If you need to follow up CLO test results, please check the log book, ProVation, or CIS. Although the CLO test result integrates into the procedure report on CIS located at the bottom of the report as an addendum, the CLO does not show up on the procedure report on ProVation due to some technical glitch; however, it can be viewed in ProVation under the 'addendum' icon.

Per Dr. Scarlett, CLO tests are read 24 hours after the sample is obtained, with the exception of tests done on Fridays, weekends or hospital holidays. CLO tests done on Friday, Saturday or Sunday are read on Monday. CLO tests done on holidays are read on the next working day.

In regard to reimbursement for hydrogen breath tests, Blue Cross Blue Shield denies breath test claims (91065) with the diagnosis of 'abdominal pain and/or abdominal bloating' because the diagnosis is inconsistent with the procedure. Therefore, BCBS does not pay and drops charges to the patient's responsibility.

There has been some concern voiced about physicians not being able to document ASA and Malampati scores on the ProVation nursing side because of the physicians not being able to access the nursing program. As of 11/04, all attendings and fellows should have access to the nursing

notes on ProVation, using the usual login and password, which allows for entry of ASA and Malampati scores in the prep area, well in advance of the actual procedure start time. Please note that documentation of ASA/Malampati scores should be performed prior to sedation to ensure that our policy is consistent and legal. At times this has been performed, but not documented. Taking full advantage of this opportunity could take time off of the procedure prep and help minimize delays in starting sedation. Since the nurses are ultimately responsible for this document, please be sure to log off once you are finished.

All fellows must state the teaching physician when generating ProVation procedure reports. The ‘physician statement’ has been added to ProVation so that fellows can automatically add this statement to the procedure report. UNC is a teaching hospital and therefore must follow certain teaching guidelines. In order to bill for a procedure, the report must indicate that the attending/precepting physician was present during the entire procedure and an attestation must appear as such to the effect ‘so-and-so was present during the course of this procedure including insertion, viewing, and removal of the scope.’”

The path reports generated by ProVation do not show the fellow as the MD who should get the report. Additionally, at times the path report does not contain a sufficient amount of information for the pathologists. Thus, a copy of the procedure report should be attached to the path slip (the path slip is handwritten by the nurses), both of which should be attached to the path bottle(s). The ProVation system has been changed so that the default is *not* to print a path slip (however, one can print a path slip by clicking on the designated box). It is critically important for faculty and fellows to use a system ensuring that all pathology reports are reviewed and all appropriate letters are written.

Motility lab procedure reports are now posted on the CIS.

It is important for all attendings to finalize procedure reports at the time they are done or at the latest before the end of the work day. Reports do not go to the CIS and cannot be billed until the attending finalizes them, including those written by a fellow. If one has any questions about finalizing procedure reports, s/he may talk to Dr. Grimm.

Additionally, everyone should get into the habit of scanning all ProVation entries at the end of each month, going back to the first of each month, to pick up any unsigned reports. Tina Blanton, our coder, can code/key in charges only for those procedures done within that month; for example, for January charges, her last day to code/key in charges for procedures done in January is Thursday, January 30th. Tina has noticed a good number of unfinalized procedure reports on a monthly basis.

Another reason to sign off on procedure reports ASAP is that, several times a day, Tina has had to contact physicians in regard to unsigned reports along with missing indications and other deficiencies. Again, failure to finalize reports in a timely manner can jeopardize reimbursements. The unnecessary delays annoy our coder, and it is not Tina’s job to contact people because of this. This problem needs to be eliminated permanently. Dr. Grimm has access to a list of those physicians who have not finalized reports.

In order to facilitate the access, viewing, modifying, and finalizing of procedure reports, in 2003 Dr. Grimm worked on having ProVation placed on physician desktop computers in the Bioinformatics Building. However, everyone should develop a check system for this: try to sign off on a daily basis, especially if you will be away for a few days; search for any unsigned reports that were overlooked at the end of the month; and make sure each report contains proper indications.

Documentation in ProVation on pouchoscopy and stoma procedures. Per our coder (4/7/11), some pouch exams have been documented as a flexible sigmoidoscopy -- the documentation of the level reached and body of the report are not clear as to what type of procedure was actually performed (example: 'scope inserted via anus and advanced 20 cm' could be either a flexible sigmoidoscopy or a pouchoscopy). There are steps in ProVation to document pouch and stoma procedures. If you do a pouch or stoma exam (ileoscopy), you should be aware that in ProVation there are software-generated templates for these exams. They should not be listed as 'flexible sigmoidoscopy'. Under Exam > Exam type....select the 4th choice: 'post-surgical lower exams'. All of the exams are listed there. If it is a stomal exam, under 'Endoscopes', select the appropriate stoma. If you notice that the nurse/technician has not done this for you, please take the opportunity to educate them.

FOLLOW-UP COLONOSCOPIES

We are receiving an increasing number of requests to place patients in our tickler file for a ten-year follow-up colonoscopy. In general, ten-year follow ups are for screening, not surveillance (three or five years). We have an obligation to keep track of all patients under surveillance because of an increased personal risk of colorectal cancer or recurrence of polyps, but this level of care is not warranted for screening patients. In all likelihood, screening recommendations will be different in ten years from what they are now. Therefore, patients who are advised to have a screening colonoscopy in ten years should not be placed in our tickler file and should be advised to continue following generally accepted screening recommendations. Patients under surveillance who are told to return in ten years are probably not getting adequate surveillance. It is important that recommendations for follow-up procedures appear in the patient discharge materials generated by ProVation. There has also been an issue whereby certain advocates feel that, for screening purposes, a flexible sigmoidoscopy should suffice and that, if what is found is questionable, the patient can be referred for a colonoscopy. However, we prefer, for the sake of thoroughness, to perform screening colonoscopies.

Screening Colonoscopies: There are several misconceptions about what Medicare will cover for colonoscopy screening. High-risk patients can undergo a screening colonoscopy every two years. For any patient who must return for surveillance colonoscopies, make sure they are scheduled to return *no sooner* than the next scheduled colonoscopy because Medicare will not cover costs for colonoscopies performed prior to that time. Such patients who return at short intervals for surveillance are not here for screening. Repeat exams for specific therapeutic reasons are covered. Indications must be complete, and do not indicate that the reason is "screening" if another indication exists. Provide as much detail in the indications section as possible. Instead of "polyp f/u," describe 1) the type of polyp, 2) its location, 3) when removed, and 4) current indication; for example: "sessile villous adenoma of the ascending colon removed three months ago: assessment for residual polyp." This is not only for insurance reasons, but it saves the subsequent endoscopist from having to look up the information on the CIS.

Additionally, Tina codes from only what is actually on the report. She has seen examples where a colonoscopy or EGD was performed, and, although the findings indicate normal with no mention of biopsies, the impression indicates waiting on path results. Per Pathology, biopsies are obtained.

Please remember to indicate findings that, not only was a biopsy obtained, but detailed information included as mentioned above so that she can code it properly.

Screening codes should be used for patients at average risk or with a condition/family history putting them at increased risk in which no polyps are found. Anyone who has polyps and is coming back for surveillance should not have a screening code. If no polyps are found on subsequent exam, a ‘personal history of polyps’ would be used as the ICD-9 code.

In short, screening colonoscopies are rendered for patients who have no symptoms. This leads to the issue of whether it is permissible to bill a consultation or a visit in addition to screening. Consultation codes are used for problem-oriented visits, and, by CPT definition, certain criteria must be met to code for a consultation. There must be: 1) a request for your opinion from another physician, 2) a documented need for the consultation, and 3) a report of findings and recommendations sent back to the requesting physician. The evaluation and management (E & M) services documentation guidelines for consultation and new/established patient codes should be considered as well. They require that you document three components: history, examination, and medical decision-making. If the primary care physician made the decision for the patient to have the screening, the medical decision-making was complete before the visit. In this case, physicians tend merely to take a brief history and/or review the hospital record prior to performing the procedure, *which is not separately billable*. In the case of a preprocedure visit, this is bundled in with the screening colonoscopy. Again, the E & M and screening colonoscopy are not billed separately, per Medicare, nor should the patient be billed separately. Per AMA coding guidelines, “While the law specifically provides for the screening colonoscopy, it does not specifically provide separate payment for a screening visit prior to the procedure. However, fee schedule payment amounts for all procedures contain payment for usual preprocedural work associated with the procedure.” However, if the patient is symptomatic, the colonoscopy would be considered diagnostic, and both the preprocedure visit and the colonoscopy would be billed separately and paid. An example of a symptomatic patient would be one who reports bleeding. If, on the E & M, in the unlikely event you have performed an unrelated problem-focused E & M on the same day you have a screening E & M, i.e., with a different diagnosis, the E & M can then be billed separately with the modifier 25.

For inpatient consults, if you already know you will be performing a procedure on the same date of service as the consult, the consult may be determined non-billable or bundled with the procedure, depending on the wording of the consult. If the reason for a consult indicates “colonoscopy” or “pre-op colonoscopy” and the consult goes on to indicate you are evaluating the patient for a colonoscopy, since you have already pre-determined that the procedure will be performed and are merely doing a consult to pre-evaluate the patient, this consult would be bundled with the colonoscopy. However, a colonoscopy (or EGD or other procedure) can be performed on the same date as the consult IF the procedure is ordered AS A RESULT of the consult, for example, “bleeding results in an order for a colonoscopy,” in which case a problem is indicated requiring a diagnostic assessment. This scenario pertains to a procedure and a consult performed on the same date of service by the SAME physician. This rule does not apply (except for the pre-determined evaluation for colonoscopy) for those patients being seen via our consult service and the procedure is performed by a different physician in the endoscopy suite.

Coding update as of 10/1/08 for screening colonoscopies.

Medicare does not pay for a screening visit prior to a screening colonoscopy. However, if you do see a patient prior to a screening colonoscopy and during the course of that visit the patient communicates other GI symptoms that are not involved with the screening colonoscopy (GERD,

heartburn) and you intend on treating those conditions, then a new patient is billable. Individuals referred for screenings should be asymptomatic. If an asymptomatic patient is scheduled for a screening, and during the initial discussion with the physician the doctor asks the patient if they have any GI symptoms and they answer ‘yes’, if the doctor documents symptoms during that initial discussion, *it is no longer a screening. A screening is utilized only for asymptomatic patients.* It needs to be communicated to the patient that during that discussion their insurance benefit may change. The same applies for when a screening turns into a surgical procedure. Perhaps when the appointment and prep information are sent to the patient, a “disclaimer” is sent along with the scheduling information to keep down phone calls from patients whose insurance carrier will not pay for that surgical endoscopy because they were expecting a screening (or diagnostic) CPT code. This is an example of such a disclaimer: “If your colonoscopy has been scheduled for screening (you have no symptoms with your bowels), and your doctor finds a polyp or tissue that has to be removed during the procedure, this colonoscopy is no longer considered a screening procedure – it is considered a surgical procedure, and your insurance benefits may change. Please check with your insurance company prior to starting the bowel preparations.” Symptoms may include change in bowel habits, diarrhea, constipation, bleeding....

Medicare has been pulling colonoscopy screenings for patients with first-degree relatives. Due to patient miscommunication regarding family history of colon cancer, Medicare has received a number of claims for patients who, by their consideration, are actually not at high risk because patients and clinic personnel do not realize that a first-degree relative is only a mother, father, sibling, child. ALL others – cousins, aunts, uncles, and grandparents are not considered high risk, but average risk. Consequently, Medicare has begun reviewing patient charts to find out just who in the family had colon cancer. Therefore, it is important that you document in the chart on the endoscopy report who exactly had colon cancer in the family. If “family history of colon cancer” is used somewhere in the chart, the family member/relative with cancer must be indicated. Many of our physicians have indicated “first-degree relative” and nothing else; this is not sufficient, and the relationship of this relative to the patient must be delineated. Otherwise, at times our physicians may perform a high-risk endoscopy for a follow up of Crohn’s disease, in which case we know why this individual is considered high risk.

Coding update as of 9/16/10 for screening upper endoscopies - varices.

Screening for varices cannot be coded as such: ‘exclude’, ‘possible’, or ‘rule out’ are not acceptable indications for coding purposes. A symptom or reason (abnormal imaging, liver disease, cirrhosis, portal hypertension) must be provided so that the endoscopy can be billed. ‘Cirrhosis – evaluate for varices’ has been included on the ‘Custom by Site’ selection for indication, which automatically populates the indication and corresponding ICD-9 codes of cirrhosis and portal hypertension.

Reports may be altered within 24 hours of entry, including coding. After that, an addendum needs to be created.

Biopsies, Therapeutic Injections, and Multiple Polyps

In the past, AMA has defined a billable cold biopsy based upon whether it was completely removed or a sample taken. If it was completely removed as a complete polypectomy, we could bill as 45385, if only a sample taken, as 45380. As of 4/02, per AGA, a cold biopsy has been redefined as merely a sample biopsy and henceforth is billed as 45380.

Additionally, previously Medicare and the AMA had determined, due to coder confusion, that billing a cold biopsy polypectomy using CPT code 45385 (snare technique) was invalid because the cold biopsy does not describe the use of a snare. However, as a result of physician interaction, recently Medicare has recognized that the description of a cold biopsy is “similar” to that of a snare and therefore should qualify as billable with the CPT code 45385. Because of physician demand, Medicare has determined that the states can make their own determination whether or not to bill the cold biopsy with CPT code 45380 or 45385. It has been determined by Cigna Medicare of NC that the description of cold biopsy was valid enough to bill the CPT code 45385. Billing 45385 for these cold biopsy polypectomies results in an increased reimbursement as the billable charge (a considerable difference between \$1300 and \$990).

For endoscopy and injection, the AGA and AMA have made a determination in the process of billing an injection with a therapeutic endoscopy, such as India ink injected after removal of a polyp and saline-injected lift technique, billed as 45381 and 45385. However, we can no longer bill this way. Per guidelines only the most extensive procedure can be billed on the same site/area, or 45385 as in this case.

When documenting multiple polypectomies, each polyp must be described in detail in addition to the retrieval technique for the retrieval to be coded. Per coding guidelines, the site and size of the polyp – including type of retrieval performed – must accompany each polyp listed. Per AMA guidelines in regard to insufficient documentation, “When an endoscopic or open procedure is performed and a biopsy is also performed, followed by excision, destruction or removal of the biopsied lesion, the biopsy is not separately reported.” Only one technique can be billed per polyp removal. Example: instead of, “Four pedunculated and sessile polyps with no bleeding were found in the sigmoid colon, in the descending colon, in the transverse colon, and in the ascending colon. The polyps measured 2 to 10 cm in size. The largest was 10 mm and located in the sigmoid at 70 cm. Polypectomy was performed with a hot snare and hot forceps. Resection and retrieval were complete.” Say this: “Four polyps with no bleeding were biopsied: one pedunculated polyp measuring 3 mm located in the sigmoid at 70 cm, removed by hot snare; a second pedunculated polyp measuring 5 mm located in the descending colon at 30 cm, removed by cold forceps; a third sessile polyp measuring 7 mm located in the transverse colon at 50 cm, removed by hot snare; a fourth sessile polyp measuring 10 mm located in the ascending colon at 60 cm, removed by hot forceps.”

For biopsy reports, make sure there is a pre-operative and post-operative diagnosis. Be specific as to how the biopsy/polypectomy was performed: e.g., snare, hot biopsy forceps, ablation. The phrase “multiple polypectomies” does not provide enough information to submit a claim. In order to get paid for different techniques within different parts of the colon, the location is essential in order to apply the appropriate modifier(s).

Coding update as of 10/26/10 for endoscopy and manometry reports.

Those of you who perform endoscopies at the hospital (no issue with Meadowmont) may occasionally run across an endoscopy that ends up on your SCID report even though you have signed the report. This is a ProVation issue. Also, some reports signed in ProVation may not have the attestation attached, when the program is supposed to automatically add it to the attending signature. For Medicare, the report may fall into your SCID report for you to add an addendum indicating the attestation. This is a random issue, and the only reports you will see on your SCID report are Medicare patients. Please add an addendum so that these can be billed: they cannot be billed to Medicare without that attestation. Regarding questions or concerns about your SCID

report, please contact our coder, Tina Blanton: pager 216-8107, phone 6-0404, fax 6-8764, home phone 919-383-8855, email tina_blanton@unchealthcare.org. For questions or concerns about the attestation issue, please contact Kevin Walter at 6-4488 or email him at kpwalter@unch.unc.edu.

Attendings who perform manometries may also see a new addition to their SCID report. P&A guidelines would like coders to have a charge lag of no more than 7 days. Any manometry charges in Tina's workfile that are over 7 days without a note in WebCis or ProVation will be sent to the physician's SCID report until the note can be completed and the charge can be billed. Since the charge in Tina's workfile does not include the attending's name, if you receive one that is not yours, you will need to let her know the correct attending so that she can change the charge to update the SCID. This will show as a missing note in SCID under "MANOM". Again, for any questions or concerns, please contact Tina.

Coding update as of 10/1/08 for multiple procedures.

One issue addressed recently by national coders has been the saline-injection snare technique and/or a tattoo performed on a polyp just removed. Up until now, it has been okay to bill these two procedures together even though they are performed on the same site. Guidelines generally indicate that only the highest RVU procedure when two are performed on the same site should be billed, but an exception was made for this particular technique. However, as of 4/07, CMS states that the submucosal injection code (45381) should not be billed in conjunction with the snare (45385) when both procedures are performed on the same lesion/site.

As a reminder, more than one procedure or test done on the same day are considered "bundled codes" and are not billable together if done on the same day. For example, for 91065, whose CPT description includes the detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or orocecal transit – all of these are included in ONE billable 91065 CPT code. More than one cannot be billed during the same session, or, in this case, on the same day. If a procedure is performed on a subsequent day, then it is billable.

Discontinued Colonoscopies

If the patient was to have a colonoscopy and the scope was inserted but did not go beyond the splenic flexure due to patient discomfort, strictures, or stool, the colonoscopy in never downcoded to a flexible sigmoidoscopy. Per Medicare guidelines, the colonoscopy should be billed as a colonoscopy with a modifier 53, indicating that the procedure was discontinued. If a flexible sigmoidoscopy had been billed instead of a discontinued colonoscopy, it would cause problems for a Medicare patient's coverage due to its 'Screening Colonoscopy Coverage Policy', which states that a screening colonoscopy will be paid "once every ten years but not within 48 months of a screening sigmoidoscopy." For this reason, the colonoscopy must be billed as a discontinued colonoscopy. Other insurance carriers generally follow this policy. As long as the physician documents in the procedure report that the procedure was aborted and the reason why, the coder can bill appropriately according to guidelines.

In an attempt to minimize aborted colonoscopies and to improve the quality of colonoscopy preps, fellows are advised to reschedule patients with inadequate preps (rather than hoping for the best and performing the procedure anyway). Patients who have had a poor response to the prep are encouraged to call and reschedule 24 hours in advance, schedule permitting. The same goes for patients who arrive and report poor results to the nurses on their intake interview. (We could consider offering a dose of Fleets Phospho-Soda and a four-hour delay for patients arriving early in

the morning.) Advising patients on what to take if we extend their prep by 24 hours is open to discussion. One must be cautious about too much Phospho-Soda, for fear of electrolyte problems. HalfLytley might be a good option for these people (prepackaged Dulcolax plus 2 liters of NuLytley). We should all convey to patients that a colonoscopy in a poorly prepped colon is potentially a waste of everyone's time and money, and that a repeat colonoscopy may be required if the initial results are inadequate. Patients with diabetes and a tendency to constipation are advised to start their prep one night early, with a dose of magnesium citrate at bedtime. Patients are also encouraged to use NuLytley instead of the original GoLyte because it has fewer GI side effects, less aftertaste, and comes in flavorings. The same applies to Colyte, although it costs more. Everyone should look for ways to reduce the amount of time spent on irrigating residue during colonoscopy. There should be two lavage syringes at each procedure encounter, which allows for one syringe to be filled while the other is in action.

Coding update as of 10/1/08 for discontinued colonoscopies. If a physician starts to perform a procedure, but, due to some complication and/or other problem no medications or anesthesia is given, the scope is not inserted, and the procedure is not performed, an outpatient (or inpatient) visit can be billed as long as it is documented in the chart. Based upon how much is documented – vitals, time spent with the patient – usually a 99212 or 99213 can be billable. Even though the procedure was not performed, the physician has spent time with the patient, for which s/he should be reimbursed.

Colonoscopy Preps. The on-call fellow can receive calls at night regarding problems tolerating the colonoscopy prep. The usual advice is to drink slower. There seems to be a consensus now, based on several studies, that taking $\frac{1}{4}$ to $\frac{1}{2}$ of the prep in the morning of the procedure actually gives better results. Patients who are having difficulty finishing the prep can be instructed to resume drinking it in the morning. Typically, we like to have four hours NPO before starting IV sedation, which in some cases might mean setting the alarm clock to 4 AM. You might find it advisable to push back the start time of a colonoscopy to allow for completion of the prep. This is better than having an incomplete prep as the outcome. In this case, please let the charge nurse know if you have advised a patient to come in a bit later than originally scheduled. This same advice applies to inpatients. Dividing the dose may improve the odds that all of the prep is actually consumed, especially in someone who drinks very slowly. Perhaps we can train the floor nurses to anticipate that if the patient does not complete the prep the night before the procedure, they are expected to resume drinking in the AM. At our recent faculty retreat, it was recommended that dividing the prep be promoted as a standard practice; however, there seemed to be little enthusiasm for this idea. Nonetheless, you may want to try it in your clinic patients to see how you and they fare with the results. Another option is do a trial of Dulcolax @ 4 tablets, followed by Gatorade/MiraLax @ 64 ounces, with the solution being split so that the patient takes 32 oz. the day before and 32 oz. in the AM of the procedure. A couple of fellows have tried this and have reported exceptional results, with improved patient satisfaction and much fewer phone calls at night on call.

In 5/07, based on accumulating data for improved results with the split-dosing method, we have decided to implement this for inpatient preps. The general advice is to give $\frac{1}{4}$ to $\frac{1}{2}$ of the prep on the morning of the procedure. ASA guidelines allow for oral intake of liquids up to two hours prior to sedation (perhaps not in gastroparetics). Outpatient standard instructions are to be revised accordingly.

Of note, the Fleets company has changed the package insert for Phospho-Soda (see <http://www.phosphosoda.com/HCP/pdfs/v5-revisedDearDrLetter.pdf>). They now recommend that the second dose of 30-45 mls be given at least 10-12 hours after the first dose. Although the

risk for nephrocalcinosis seems negligible, the Phospho-Soda instructions should be changed to this effect for medical and legal reasons. The GoLyteLy representatives are using this change as a reason to promote their new product, HalfLyteLy. Fleets is under \$4 per bottle, whereas HalfLyteLy is \$50 at a discount chain. Dr. Grimm plans to alter our Phospho-Soda instructions to include a 10-hour delay between doses. Phospho-Soda prep instructions can be found at <http://www.phosphosoda.com/Cons/>.

THE NATURE OF PROCEDURE LETTERS

Procedure letters must be dictated to document any kind of GI procedure performed (EGD, colonoscopy, flexible sigmoidoscopy, ERCP). Generally a letter contains both the reason for referral/findings followed by the results returned from pathology, if any. Along with findings and whatever pathology this might entail, a care provider can provide recommendations for treatment. Sometimes a care provider may say something like, “At UNC for H. pylori we offer triple antibiotic therapy consisting of...; however, we leave treatment at the discretion of the patient’s primary MD,” or simply, after providing findings/results, “We leave care at the discretion of...” There are standard phrases used as well in regard to follow up, depending on the outcome of findings, i.e., an adenomatous polyp versus a hyperplastic one.

In particular, pertaining to the finding of an adenomatous polyp, the care provider can state, if applicable, something like “Because individuals with adenomatous polyps have a tendency to form additional polyps in the future,…” Patients should receive a copy of a procedure letter. The care provider may put a statement such as “By way of this letter, I am informing so-and-so of the findings and results of her flexible sigmoidoscopy.” In addition, a care provider may want to address follow-up care by saying something like, “I have taken the liberty of putting so-and-so’s name in our tickler file for a repeat colonoscopy in September 2004.” Some care providers go into more detail, such as describing the site and size of polyps or how a polyp was removed (e.g., snare) or the type of biopsy performed (cold, hot).

Dr. Craig Cender, former fellow, has developed a series of standard form letters for procedures that have been entered into the ProVation system for the fellows to use depending on the type of procedure performed, pathology results, and treatment recommendations.

In regard to the sending out of path follow-up letters to patients, since patient names and addresses appear automatically in the system, when patient letters are printed out, the name and address appear in the letter, which can be sent directly to the patient. The Procedures Unit orders window envelopes so the fellows can just put the letters in the envelopes and mail them out from there. However, the fellowship coordinator does not mind doing this on their behalf as well.

In terms of procedure reports, initial reports are faxed to outside referring physicians. Reports generated for in-house MDs are not sent out because the physician can look up the results on the CIS. GI Procedures takes no responsibility in sending out subsequent path follow-up result reports or letters. Path reports are entered by the physician for faxing to referring MDs, and cc’s to patients are mailed to them.

ProVation is currently unable to store digital images on the CIS or PACS. Therefore, procedure reports containing clinically significant images should be sent to medical records for filing. To assist in deciding whether you should send copies to medical records, Dr. Grimm suggests sending only those reports whose images would be of value to non-GI physicians. To send copies to medical

records, place an extra paper version in the top wall pocket slot ('to UNC Medical Records') outside of room 2. To send copies to referring physicians, place a copy in the 'outgoing correspondence' slot, along with a ProVation form letter. Fellows are encouraged to send as many interesting images to referring MDs and primary physicians at the time of the procedure; however, we do not need to send paper archives to medical records, only in exceptional cases, because paper archives is becoming obsolete. Postage for reports mailed from GI Procedures is paid by the hospital.

DATES OF SERVICE FOR PROCEDURES

Please watch the dates of service that you enter for your procedures in ProVation. There have been several instances—mostly for pediatric GI—where the report was dated the day after or the day before the actual procedure was performed. For pediatric endoscopies, this is often found and verified by Anesthesia because their date of service differs from the date on the endoscopy report. When brought to the coder's attention, the information is sent back to the physician for correction of the date of service on the report, after which the claim is refilled. This can cause a delay in reimbursement.

For adult GI endoscopies, the coder has no way of knowing whether or not the date of service is correct. She prints a report from ProVation for each date of service and goes by that for coding/billing. There have been a couple of cases of inpatient endoscopies performed that insurance carriers have denied because the date of the endoscopy was given as the day after the patient was discharged, when actually the patient was in house. In this case, the charge was entered as outpatient because the coder had no way of knowing that the date of service was incorrect. The coder can know of such things after the fact upon review of records and in conversation with attendings. Please be careful and make sure that the date of a procedure is correct so there will not be any delays in reimbursement. This is especially relevant if the insurance carrier is an HMO requiring pre-authorization and has already authorized for a particular date of service. If you enter a note AFTER the date of service, please remember to change the date to the actual date that the procedure was performed. If you have any questions, please contact Tina Blanton, GI Procedures Coding Specialist, tina_blanton@unchealthcare.org, pager 216-8107, 6-0404.

When entering information into ProVation, please consider these important reminders:

- Please check to make sure the correct room number is entered so we can track room use. Even though the nurses are supposed to input this data, but this may not always be entered or entered correctly.
- Insertion site and level reached are required for any procedure to be billed and therefore must appear on the report. You must ensure that this information is entered and documented. As of 2/05, 'type of scope' is no longer necessary as part of documentation for billing. However, the type of polyp (hyperplastic, adenomatous), its size, location, and, if biopsied, technique (snare, forceps) and type of biopsy (hot, cold) all must be included in the report.
- You are encouraged to modify the indication field when entering reports into ProVation, which can be done by clicking on 'other' when entering indications. This field provides more information, such that data is readily available for subsequent endoscopists, especially in regard to follow-up recommendations. This is of particular importance if the patient did not receive a preprocedural consultation. If the indication is 'previous polyps', be specific and state '2 cm tubular adenoma removed from sigmoid in 1999' rather than simply 'polyp f/u'. Another example would be, for cancer, to state the degree of relative affected and the

age when it was diagnosed. If the 'other' field is used under 'impressions', the free text appears automatically as part of the letter to the referring physician.

- Some GI procedure reports never make it to the CIS because of an invalid medical record number. MR numbers must consist of 12 digits, including the check digit at the end as the 12th digit and then zeros at the beginning. If the number is not denoted as such, it will not be posted on the CIS because it is not recognized.
- Some GI procedure reports never make it to the CIS because they have not been finalized. It is of vital importance that procedure reports be finalized by the attending listed within 48 hours post procedure. This is particularly important for inpatients; often our consult team has checked the CIS to find results of inpatients who have gone down to procedures earlier in the day and there has been no report because it has not been signed – reports do not go over to CIS until the attending signs.
- In many instances, the issues above pertain to liver biopsies, OR cases, and travel cases. This is not a frequent occurrence for cases treated in GI Procedures because the patients are checked in by us, and the ProVation system interfaces with SMS, where the patient should be listed correctly. If you need to input a patient manually, please make sure this is done correctly so that the report gets posted to the CIS. The nurse supervisor has spent many hours manually fixing incorrect report entries: it is the responsibility of the physician to make sure information entered is correct and to adhere to the reminders above.
- Make sure that the ProVation recall system is the final word, just as AMION is the final word for schedules. Everyone is encouraged to use the menu-driven recommendations about follow-up intervals, e.g., follow-up colonoscopy in three years. This automatically puts patients into our reminder tickler file. Hence, those reading the report knows the plan, avoiding the need for additional subsequent information. This helps the physician later when referring to the report for the next planned procedure. Any time that a change is made regarding a recommended recall date, the physician involved needs to make the appropriate change on the ProVation recall system. This should not be a problem because one is prompted to do so whenever path follow ups are entered into ProVation.

Pathology Follow-up System

1. All patients with potential for malignant disease and S/P bowel cancer are put in the GI Procedures Unit follow-up system (e.g. Barrett's esophagus, gastric ulcer, IBD, adenomatous polyp).
2. It is your responsibility to be certain that appropriate follow up is scheduled for every patient whom you endoscope and who needs follow up. If you are uncertain, ask the endoscopy attending.
3. Please complete a follow-up procedure requisition as soon as the Path Report indicates need. Be sure to note special patient needs such as prophylactic antibiotics, etc. Give completed requisitions to the GI Procedures scheduling secretary.
4. F/U appointment reminder letters are mailed by the GI procedures secretary or the head nurse. If there is no response a second and final letter is mailed, with a copy to the patient's chart.
5. Requisitions are retained in the patient's F/U folder and pulled by the appointment secretary for the F/U procedure. Patients requiring pre-procedure treatments are asked in their initial appointment letter to schedule an hour in advance of the procedure.

6. A box containing the next few months of F/U folders with requisitions is kept in the appointment secretary's office. A paper clip on the upper left corner indicates there is no requisition for F/U recommended by the MD upon review of the Path Report.
7. ProVation can be used for pathology follow up and for scheduling follow-up procedures, for which ProVation can generate requisitions. The clerical staff enters an indication for the procedure, based on the appropriate CPT code. Contact information for referring physicians and special indications (e.g., obtain duodenal biopsies) can be entered and should be made available to the person performing the procedure. The easiest way to schedule a follow-up procedure is to check 'repeat study' under the 'recommendations' menu as you enter the report. To schedule follow ups after initial report entry, go to 'patient recall' on the main menu screen.
8. We have had several errors and near misses involving patients with the same name and middle initial who both had procedures on the same day (9/22/10). Both patients had pathology specimens sent under the same name. A report was entered on the wrong template. Please remember to check that the MR number on the wristband matches the MR number on the ProVation template when you do your time out. Also, make sure that ALL members of the team are aware of any name alerts. We should take time out for a checkpoint at the end of any procedure in which specimens are obtained. The nurse should read back to the endoscopist all information pertaining to path, including location of biopsies and the name of the physician to whom the pathology report will be sent. The MD name on the stickers affixed to the path jar must agree with the name on the pathology request.

Pathology Review takes place on Thursdays from 7:30 a.m. to 8:30 a.m. in the pathology residents area of the third floor of the Women's and Children's Hospital. Since only one hour is devoted to pathology review, efficiency is premium, and only pertinent cases are to be brought for discussion. A continental breakfast is provided.

GI BIOPSIES

Per Pamela Groben of Pathology, it is not unusual for the number of pieces of tissue noted at the time a GI specimen was grossed to be somewhat different than the actual number seen on the slide. Tissue processing can break up small, fragile pieces that can be washed away by fluids flowing in and out of the processing chambers. Sometimes biopsies are friable and sometimes, though rarely, even consist of feces rather than tissue. The specimen may also stick together at the time it is grossed and then break apart during processing, resulting in more pieces of tissue than originally noted. This phenomenon seems to be more of a problem with fragile GI specimens than with fibrotic ones. Although cassettes used by Pathology have fine mesh screens to prevent this problem, this is not always effective.

Serrated Adenomas. Our pathologists, along with many others, find a degree of ambiguity in the histopathologic diagnostic criteria for serrated adenomas, not typical for other diagnostic entities encountered. Our pathologists can usually recognize serrated polyps with accuracy and precision, but probably not with as good an inter-observer agreement as with typical adenomatous polyps. It is our opinion that serrated polyps should be managed clinically like adenomatous polyps, with repeat endoscopies at appropriate intervals. It may be concluded with further study that certain subsets of serrated polyps carry a greater risk for evolution to carcinoma and that re-biopsy of the polyp base is

therefore appropriate. However, we are not at that point yet, and, thus far, histopathologic diagnostic criteria have not been adequately developed to permit reproducible subdivision of these polyps.

Communication with Referring Physicians

The following policies have been adopted to facilitate communication and to prevent patients from “falling through the cracks.”

1. A letter to the referring physician should be prepared by the fellow or faculty member performing the procedure for each outpatient having a procedure in the GI Diagnostic and Treatment area. The only exception is for GI Division members (faculty and fellows) who see the patient in clinic the day of the procedure. If patients are not seen by a Division member the day that the procedure is done, they will also require a letter. Letters should always be sent to members of other divisions or departments and outside physicians, even if verbal communication has been made. This requires organization and discipline.
 - a) In complicated or controversial cases, direct communication by telephone is preferred, but should be followed by a letter to document the conversation.
 - b) 3-hole punch a copy of every report and place them chronologically in a large 3-ring binder with dividers for each month. Do not put EGD and colonoscopy reports in different binders. At the end of each week retrieve the pathology and CLO test results for all the cases done the previous week. Write results on your copy of the procedure report. Go into ProVation and prepare a letter to each referring MD. Choose the appropriate letter template based on procedure type, biopsy result, and treatment recommendations and customize or modify accordingly. A letter should be sent to the referring MD, with a separate letter to the patient. If the patient has undergone two procedures such as a colonoscopy and an EGD, s/he will receive two different letters in accordance with each procedure type, yet both can be sent in one envelope. Template letters to patients are composed in language that the patient should understand. If a follow-up procedure is required, complete a requisition. The requisition should be correct as of the date completed. Give completed requisitions to the Procedure Area scheduling secretary.
 - c) Upon completing each letter, note what you did on the bottom right hand of your copy of the report for your reference, e.g.
 - 5/7/00 – letter dictated to Dr. Rodney L. Jones and to the patient
 - rec. – colon in 3 years
 - req. – sent for 5/03
 - d) Once you and an attending have signed the letters generated from ProVation, write “complete” on the report.
 - e) You will receive copies of the pathology reports in the mail from Pathology, but they often arrive too late to meet the 14-day deadline. When they arrive, you may use them to double check the path report generated from the computer; 3-hole punch and insert the path report behind your copy of the procedure report.
 - f) You may receive copies of pathology reports stamped “follow up” from the GI Procedures office. Write follow-up plans, e.g. “colon in 3 years” on this report and either attach a requisition or note that a requisition was previously sent. Return these to scheduling secretary.

- g) At the end of each month use the page(s) containing labels for all pathology sent in your name to double check your reports to assure that you have not overlooked any pathology reports.
 - h) If you feel you have a better plan for managing communication with referring MD's and following up on pathology, please do not use it until your plan has been discussed with and approved by the fellowship program director.
2. Communication with the referring physician of inpatients is the responsibility of the ward attending physician of record or the responsible GI attending. However, if you do the procedure you must write the ward attending physician or responsible GI attending as you would any other referring MD.

GI PROCEDURES

SCHEDULING SYSTEM

1. Residents on the gastroenterology inpatient service can schedule a GI procedure by writing an order in the chart. The attending on the inpatient service is ultimately responsible for performing that procedure but it may be done by the endoscopy team, biliary team or endolyte attending depending on availability. Any patient not on the GI inpatient team is the responsibility of the consult attending or the liver attending and the ordering physician will be instructed to call the GI consult fellow.
2. The GI surgeons (Drs. Koruda and Farrell) may schedule inpatient procedures without having a GI consult. All other inpatients must have a GI or liver consult or approval of the GI or liver consult attending before the procedure is done.
3. When you are requesting a procedure on a patient you have seen, please indicate who you would like to perform the exam, assuming that you do not intend to do it yourself. If you do not care to specify a specific provider, then ask the schedulers to add a comment such as "GI Medicine to do" or "GI Fellow to do". If you do not specify a provider for that procedure, the charge nurse will assume the case can be assigned to the surgery department, even if it is one of your regular clinic patients. Ideally, we should perform all of the procedures requested on patients we have seen within the division. But without clear instructions, the charge nurse may distribute any patient that is not a specified a 'to do' case to the surgeons.
 - It would be helpful to the charge nurse if you can identify potential GA or propofol recipients when scheduling the procedure. We should designate "propofol ok" to indicate that the anesthesiologists can sign up the patient.
 - The anesthesia department wants to do 16 cases a day in our unit, to meet their financial goals, in this way helping us out. An ASA score of III and above qualifies a patient to undergo anesthesia with propofol. ASA inpatients are scoped on Wednesday or Thursday, with notification to the schedulers (Nia Riggsbee or Kelly Verner).
4. Same day outpatient procedures must be reviewed by the endoscopy attending since the endoscopy team will likely be performing the procedure and should know what the overall flow in the unit is and the availability of the team to do the procedure.

5. Requisitions are required for all procedures. For inpatients entering the information into the SMS generates a requisition and this must be done even for emergency cases done at night or on weekends. All outpatients should have a completed GI Procedures requisition.
6. Physicians calling from the outside to schedule a procedure must submit a requisition for the procedure by mail or by fax (919-966-0285). Biliary procedures need to be scheduled through the biliary fellow. If there is no space on the schedule in the time frame that the referring physician wants the procedure done the call should be given to the endoscopy fellow/attending so that attempts to facilitate the procedure can be made.
7. The new referral form for endoscopic procedures drawn up in 10/03 replaces the old GI Procedure requisition form, which is available on our division web site www.med.unc.edu/gi (user name GasHep, password UNCGI). The line for 'outside' physician should be filled in whenever possible so that faxes from ProVation are sent to outside referring physicians. *Charts are no longer ordered on a routine basis since most information is posted on the CIS. If a chart is needed, Medical Records assures that one can be called up and arrive within an hour.*
8. As an ongoing issue about which the GI Procedure receptionists have voiced dissatisfaction, please use the fellows' fax 843-3521 or the one in the conference room 966-0285 if you need to send or receive a fax because the receptionists need their fax machine at all times to send and receive information pertaining to the scheduling of patients for procedures. To this end, please do not give out the staff's fax number for others to use.
9. Urgent endoscopy cases that cannot be fit into the routine procedure schedule may be scheduled as add-ons. This would most often apply after hours when the schedulers are unavailable to find a slot in the schedule. Two matters are essential:
 - The patient must be told s/he is an add-on and will need to wait, with no assurance that the procedure will start at a specific time. Advise the patient to bring 'a good book'.
 - There should be legitimate medical urgency in such a case; otherwise, we run the risk of insurance denial. Instruct the patient to come at 8:00 a.m. with all of his or her insurance information, and leave a note for the charge nurse and schedulers, indicating that you have put an add-on into the schedule.
10. When you are requesting a procedure on a patient you have seen, please indicate who you would like to perform the exam, assuming that you do not intend to do it yourself. If you do not care to specify a specific provider, then ask the schedulers to add a comment such as "GI Medicine to do" or "GI Fellow to do" or whatever you like. If you do not specify a provider for the procedure, the charge nurse will assume the case is fair game for the surgery department to do, even if it is one of your regular clinic patients. We should perform all of the procedures requested on patients we have seen within the division. But without clear instructions, the charge nurse may distribute any patient that is not a specified "to do" case to the surgeons.

Also it is extremely helpful to the charge nurse if you can identify potential GA or Propofol recipients when the procedure is scheduled. In many cases we should probably use terms such as "propofol ok" to indicate that the anesthesiologists can sign up the patient, but that it is not essential.

11. Per institutional policy, family members are not allowed in the procedure unit proper.

Effective 5/1/03, GI Procedures scheduling system switched to IPATH, the system used by the operating room. The schedule can be viewed on CIS under ‘operating room schedules’. All colonoscopies are scheduled for 45 minutes, and all EGDs are scheduled for 30 minutes. If you are scheduling a case and anticipate that it will be complicated, please ask the schedulers to block out additional time, in blocks of 15 minutes. For example, if a patient is referred for a colonoscopy for removal of multiple polyps, you should schedule an hour, or as much additional time as you think might be necessary. The idea is to try and optimize room utilization without scheduling more than is possible in the allotted time. Please do not put in a procedure in a space without notifying the receptionists or in an attending slot without notifying the attending’s secretary.

When scheduling procedures using IPATH, the schedulers routinely ask for the ‘referring physician’. We should list outside physicians as ‘referring’ rather than members of our division, since this ultimately triggers the system to list the patient as the referring physician on ProVation. When the report is finalized on ProVation, it will be sent to the CIS and faxed to the listed referring physician. If there is a mismatch between the referring listed on IPATH and the person to whom the fax is sent, we receive an error message regarding the fax recipient. For example, if you do a colonoscopy on a patient sent to you by Dr. Alan Smith and you are listed as the referring physician on IPATH, an error report will be generated if you try to change the referring name to Dr. Alan Smith once you enter the procedure report into ProVation. Therefore, when asked ‘who is the referring physician’, the answer should be the person to whom you want a procedure report sent, NOT the physician who requests that the procedure be scheduled.

Start Times in GI Procedures

In 3/07, we have initiated a renewed effort to ensure that cases start promptly in the morning. To this end, nursing schedules have been moved up in the AM so that there will be sufficient staff to get all of the rooms ready for use first thing in the morning. This means that a patient should be in every room with an IV in place at 8 AM (or 9 AM on Thursdays). The goal is to have a scope insertion time of no later than 8:15 AM in three of the rooms at Memorial. ProVation software allows us to track to what extent we reach this goal. It is essential that all assigned physicians be on site no later than 8 AM, preferably a bit earlier in order to gather histories and obtain consents. Starting the day promptly is one of the easiest ways to improve our overall efficiency. But everyone’s assistance is necessary in this endeavor so that our unit runs as smoothly as possible.

We are required to obtain an obstetrical consultation before performing any type of procedure on a pregnant woman. On September 6, 2002, The Board of Directors of the UNC Health Care System approved and adopted this addition to the Rules and Regulations of the Medical Staff. This measure was discussed and approved by the Clinical Management Committee (CMC) and the Medical Staff Executive Committee (MSEC), with input from the hospital Legal Department and the Housestaff Council. The measure reads “Consultation with the obstetrical service is required when a known pregnant woman is admitted to a service other than Family Medicine or Obstetrics/Gynecology. A preoperative consultation with the obstetrical service is also required when an inpatient or outpatient operative or other interventional procedure is planned for a known pregnant woman.”

Consent forms are posted on our division web site <http://uncgihep/med.unc.edu>, user name GasHep, password UNCGI, in both English and Spanish. Effective 2/4/03, all inpatients should have their procedure consents performed before leaving the floor, preferably the night prior to the

procedure, unless they are referred without a consult. To facilitate this, since our consent forms are now posted on our web page, they can be printed out directly from the floor. If possible, the physical assessment should also be done prior to transport. All outpatients should have their consents performed by the appointed starting time. The nursing staff make every effort to have all 8:00 a.m. patients ready and in the room with an IV running, so please report on time so that sedation can begin promptly at 8:00 a.m.

Pre-sedation information must be completed before beginning sedation. This must include documentation of “adverse airway or prior sedation history, known medical or psychiatric instability, as well as the airway, pulmonary, and cardiac exam.” Document, if necessary, “decision to request anesthesia consultation in cases that have a history of a failed attempt at moderate sedation, of a complicated airway, if the patient is medically or psychiatrically compromised or considered to be beyond GP’s level of expertise.” All procedure room doors must remain closed during the length of a procedure. Nurses must ask each patient to score any pain they may experience. If the score is five or greater *and* GI related, the unit is responsible for documenting this: the RN should notify the MD and document this fact, while the MD should document what s/he did about the pain, even if nothing was done about it.

Policy regarding pre-procedural antibiotics

The goal of this policy is to eliminate delays in procedure start times to maximize time and efficiency in terms of patient flow in the unit.

- All patients requiring pre-procedural antibiotics should be identified well in advance of the procedure date, whenever possible.
- Outpatients requiring IV antibiotics should be instructed to arrive an hour earlier than usual. Ampicillin and gentamicin are kept in stock in the procedure unit. A prescription for oral amoxicillin may be preferable in patients at high risk for endocarditis since post-procedure doses can be prescribed concomitantly.
- Inpatients requiring antibiotics should have orders written by the GI consult team. The antibiotic should be available on the floor well in advance of the anticipated procedure time.
- The consult fellow is responsible for notifying the charge nurse of all inpatients who will require antibiotics. The charge nurse will call the floor an hour prior to the procedure and instruct the floor staff to start administration of the drug.
- Most therapeutic ERCP procedures should be performed under antibiotic coverage (e.g., obstructed bile duct, suspicion of or potential for cholangitis, pancreatic pseudocyst, pancreatic duct disruption). In patients without penicillin allergy, the default choice should be Cefotetan 1-2 g IV. This will be kept in stock in GI procedures. If unavailable, Cefotaxime will be substituted and kept in stock. (We generally administer vancomycin to those patients with penicillin allergy.)
- Avoid the use of IV Cipro before procedures. The infusion requires an hour, and sedatives cannot be administered through it.

- All PEG and PEJ procedures require antibiotic prophylaxis. Cefazolin, one gram, IV, 30 minutes before the procedure is the default prescription for patients without penicillin allergy.
- Because inpatient preps for colonoscopy tend to be slow, in order to expedite colonoscopies and minimize delayed preps, we should order GoLyately to start in advance of the usual time, meaning you should write the order to ‘start prep now’.

Special Requests: At times, there may be special requests on inpatients, in which case the GI or hepatology consult fellow should write in large letters at the top of the requisition/charge sheet for each inpatient any and all special requests. The charge sheet contains the input attending’s name, which should be entered as the referring/requesting physician. The endoscopy fellow for the day should be made aware of any special cases. This is also so that this fellow has an opportunity to be involved in what is usually an interesting case, not just common GERD or screening cases. In the event an endoscopy fellow is not present for the day, the consult fellow should still talk directly to the endoscopy attending about the case, and then make sure that the charge nurse assigns the case to that attending.

Additionally, Dr. Koruda of GI Surgery has requested that we provide more information in procedure reports pertaining to patients with a Hartmann’s pouch. Specifically, he would like to see the length of the pouch mentioned, as this is crucial in planning subsequent surgery.

Policy regarding infection control in GI procedures

Patients who are on isolation (e.g., MRSA, VRE) can create significant difficulties in maintaining infection control guidelines, when these patients are brought to GI procedures. In general, any patient residing in an ICU should have their endoscopic procedure done as a travel case, but this is especially the case for patients on isolation. For this reason, we are in favor of sending GI procedure nurses on travel cases, as certainly patients in ICUs should not travel to procedures if they are unstable in any way. ERCP, EUS and fluoroscopic cases are generally exceptions to this guideline.

The rooms in GI procedures do not need to be ‘terminally cleaned’ after a patient on contact precautions has had an endoscopic procedure. Below outlines the necessary precautions that should be followed by personnel in GI procedures when they are working with contact isolation patients:

- Wear gloves for all interactions with the patient, managing equipment such as their stretcher, and when entering the procedure room when the patient is present.
- Wear a yellow isolation gown when having direct contact with the patient such as moving them from procedure table to stretcher and during the procedure (you can omit the yellow gown during the procedure only if you are wearing a cover gown that is disposable or one that you can remove after the case and put on a clean one).
- After the patient leaves the procedure room, clean the reusable equipment that had direct contact with the patient and the equipment you handled with gloved hands during the procedure. Cleaning can be done by wiping the surface with the germicidal cleaner you normally use for room cleaning. Do not forget to wipe the bed rails, blood pressure cuff, etc. in the recovery area as well.

- You do not need to have housekeeping terminally clean the room. Housekeeping should follow their normal cleaning routines for GI procedures.

Steps for Scheduling General Anesthesia for GI Procedures

1. Tentatively schedule a time with the GI Procedure secretary and the patient, preferably at least two days in advance.
2. Obtain approval from an Anesthesia Attending.
 - a) Call the front desk, 6-4355, and find out the name and pager number of the attending.
 - b) Get the attending to “pencil in the time” that you have arranged with GI Procedures and the patient.
3. Get on the O.R. schedule.
 - a) Call 6-3680 to get a “posting form.” (The form should also be in a red folder labeled “G.A.” in the GI Procedures reception area.)
 - b) Hand carry the completed form to O.R. scheduling in Pre-Care or fax it to 6-3797.
 - c) Follow up with a phone call (6-3680) to ensure receipt of the form.
 - d) **THIS STEP MUST BE DONE BEFORE 10:00 A.M. THE DAY BEFORE THE PROCEDURE.**
4. Within 30 days of the procedure, interview and examine the patient and complete the history and physical exam parts of the pre-procedure assessment form and send to Pre-Care. The form is available from Pre-Care but also should be in the red folder labeled “G.A.” in the GI Procedures reception area.
5. Have the patient seen in Pre-Care on the first floor of the Hospital. Call to let them know when the patient will be there (6-2273 or 6-3326).

As of 7/15/02, operational details concerning GI use of general anesthesia for patients undergoing procedures are as follows:

- The anesthesiology department does not do conscious sedation or so-called MAC cases. Anesthesiology limits its availability of services to deep sedation/general anesthesia.
- Elective endoscopy cases to be performed in GI Procedures and requiring anesthesiology services can be scheduled by contacting the daily anesthesiology coordinator. The main O.R. desk (6-4355) can direct a GI physician to the anesthesiology coordinator. Priority is given to the GI service if more than one case is scheduled back to back on a given day. Thus, if GI Medicine aggregates several procedures requiring general anesthesia, a team can be scheduled for half a day in that area.
- The GI service may elect to perform their cases in the O.R. for medical indications. Anesthesiology can accommodate those cases as well. For example, a critically ill patient in the ICU might be more safely monitored and cared for in the O.R. rather than risk being subjected to a lengthy transport.
- Anesthesiology will advise the GI service when coverage is available in a frame of time around the requested date and time but cannot guarantee the availability of the requested date and time. GI physicians may need to readjust their schedule to accommodate anesthesiology’s schedule.
- Often anesthesiology schedules multiple cases throughout the hospital for a single team on a given day. This means that cases must begin and end on time. If GI Procedures cannot start or finish a case when it is scheduled, it will need to be rescheduled. Patients must be available to be

seen by an anesthesiologist in GI Procedures *at least 30 minutes* before the scheduled start of the procedure. It is the responsibility of GI Procedures to arrange for both inpatients and outpatients to be in the suite in advance of the scheduled start of the procedure. Late patients will need to be canceled and/or rescheduled.

- All patients receiving anesthesiology services in GI Procedures will be recovered in the main PACU.
- A physician from the GI service will accompany the patient from GI Procedures to the main PACU at the end of the case, will give a report to the PACU nurses, and will write orders for the patient's care in the PACU and beyond.
- Cases that receive approval for anesthesiology coverage will be posted by GI Procedures with the O.R. Scheduling Office at 6-3680. If GI Procedures wishes a patient requiring general anesthesia to undergo the procedure in the O.R. because of medical complications, this can be arranged through the O.R. Scheduling Office.
- It is the responsibility of GI Procedures to ensure that a patient is medically prepared for general anesthesia. This means that a current *and complete* medical history and physical must be present in the chart for the anesthesiologist's review. To this end, the GI service may request that an outpatient be seen in PreCare or otherwise ensure that outpatient charts contain a current and complete medical history and physical available for the anesthesiologist's review. Patients who do not present with a current and complete medical history and physical will be canceled. In addition, inpatient charts should contain sufficient medical information to allow for a preoperative anesthetic evaluation.
- All patients, both outpatient and inpatient, should be provided with appropriate pre-procedure fasting instructions, and it is the responsibility of the GI service to do this.
- Emergency endoscopies performed in less than 24 hours requiring general anesthesia must be performed in the main O.R. These cases can be posted by calling 6-4355. In such a situation, Anesthesiology does not have the resources to go directly to GI Procedures. However, endoscopies can be performed in the main O.R. (although this may be somewhat inconvenient for the proceduralist). Similarly, all "on-call" cases (night and weekend endoscopic cases) requiring general anesthesia must be performed in the main O.R.

Conscious sedation is used when a patient undergoes a procedure requiring a certain amount of sedation to cause a depressed level of consciousness, such that the patient continues to retain protective reflexes, maintain a patient airway, and respond to physical stimulation and/or verbal direction. *Please do not discuss personal matters or issues unrelated to the procedure at hand.* This has been a problem in the past whereby some patients have complained that they were able to hear conversations unrelated to their case or medicine. During a procedure, patient privacy must be maintained by making sure curtains are always drawn around each patient in the prep/recovery area. ('Privacy' refers to what is *visual*.) Patient confidentiality must be maintained by not leaving reports and records lying around where others can see them and by speaking quietly so that only the patient can hear. Discarded reports should be torn once or twice. Both 'privacy' and 'confidentiality' are patient rights. The conscious sedation post-test and supporting materials can be found at <http://medicine.med.unc.edu/forms/form.htm>.

Subspecialty residents take the conscious sedation test, which they must pass, as part of the Housestaff application process. For fellows appointed to the Medical Staff, the taking and passing of this test is also required as part of the Medstaff application process.

The GI Procedures Unit has been tracking the use of reversal agents, in particular Narcan, as an ongoing outcome measure in an attempt to develop a plan for reducing the need for use of such agents.

We have a combination injector and bipolar probe available on the travel cart, called the Interject. Feel free to use it when you anticipate combining an injection of epinephrine with thermal therapy for hemostasis. Since these devices are quite expensive, please avoid opening one when a single modality device is preferable. Also be aware that 10 French bipolar probes do not fit in the non-therapeutic gastroscopes, so only open a 7 French probe if you have a diagnostic gastroscope. All therapeutic gastroscopes are named beginning with the letter T.

The hospital conscious sedation guidelines are of considerable concern to our nurses, who at times feel they are being asked to sedate faster than is permissible by the guidelines, or faster than what might be safe for the patient. It is essential that we all understand and agree about how sedation should be done in our unit. Patients should be sedated as quickly and as safely as possible. If every patient took 20 minutes to sedate, and we did 45 procedures per day, the time spent waiting for drugs to take effect would be equivalent to two nursing FTEs. Some studies suggest that a bolus of sedatives at the beginning of a procedure is more effective than titrated dosing and no more risky.

We may give a rapid bolus of Versed 2 mg and fentanyl 50 mcg to most healthy patients without violating the hospital conscious sedation guidelines. The two drugs can be pushed in simultaneously and need not be administered over several minutes.

In a study done by Morrow, bolus sedation proved superior to titrated sedation. In this study, larger patients received larger doses, with heavy patients (> 90 kg) under age 35 receiving 3 mg of Versed and 75 mg of meperidine. Exclusion criteria in the study were age < 18 or > 65, active use of narcotics or benzodiazepines, NYHA class CHF III or IV, lung disease requiring home O₂, and end-stage liver or renal disease. We suggest that you follow this exclusion criteria.

The nurses sedate slowly because the physician is not in the room, and the physician may not be in the room because of slow sedation. Hence, the only solution is that the physician must be in the room when the bolus is administered. If the nurse feels uncomfortable in administering it, the physician can administer it.

Since fentanyl may cause more respiratory distress than meperidine, we need to monitor carefully for apneas occurring after bolus sedation and report any adverse events with the bolus technique.

GUIDELINES FOR CONSCIOUS SEDATION

I. Policy:

- A. Increasing numbers of ambulatory and hospitalized patients require diagnostic and therapeutic procedures. Many of these patients also require sedation to undergo such procedures. The safe use of sedation requires appropriate assessment, monitoring and aftercare. These guidelines focus on the use of conscious sedation during the performance of surgical and/or other procedures.

II. Definition of Conscious Sedation:

The desired goal, conscious sedation, is a minimally depressed level of consciousness that retains the patient's ability to maintain a patent airway independently and continuously, and respond appropriately to physical stimulation and/or verbal command, e.g., "Open your

eyes.” For the very young or handicapped individual, incapable of the usually expected verbal responses, a minimally depressed level of consciousness for that individual should be maintained. The caveat that loss of consciousness should be unlikely is a particularly important part of the definition of conscious sedation. The drugs and technique used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely.

Deep sedation is to be avoided. Deep sedation is a controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused, which may be accompanied by partial or complete loss of protective reflexes, including the ability to maintain a patent airway independently and respond purposefully to physical stimulation or verbal command. This state of sedation/analgesia should only be provided by a qualified anesthesia practitioner.

If it is the intent of the practitioner to induce a state of conscious sedation (versus relief of anxiety) then the following guidelines must be adhered to and documented in the medical record.

B. The Urgency of the Procedure must be Considered:

1. **Elective:** If possible, procedures should be done when conditions are optimal for the safety of the patient. Important factors to be weighed include the probability that the patient’s condition will worsen with delay, the availability of key personnel, equipment and facilities.
2. **Emergency:** In some circumstances, diagnostic or therapeutic, intervention is required immediately to provide for the patient’s safety or comfort. Frequently, sedation and/or potent analgesia is necessary for primary pain relief during diagnostic or therapeutic procedures performed on an emergent or urgent basis. The risks and benefits of sedation must be considered on an individual basis. If operative intervention is likely to follow the diagnostic procedure, it is important to obtain operative consent prior to sedation. Typically, the following factors should be weighed:
 - a. Urgency of the need for sedation
 - b. The level of sedation required
 - c. The risks inherent in providing sedation (airway patency, respiration, oxygenation, CV stability)
 - d. The risks associated with delay in therapy

For example, IV opioids are indicated for pain relief early in the evaluation and treatment of renal colic, while intravenous anesthesia for the repair of flexor tendon lacerations of the hand might reasonably be delayed in order to optimize total patient care.

C. NPO Status: General Guidelines: A patient should not have a full stomach if sedation, sufficient to place a patient at risk for aspiration of gastric contents, is to be given.

1. Elective:

- a. All patients should be NPO for solid foods for six hours prior to elective procedures.
- b. Children should be NPO for solid food for four to six hours, but may have clear liquids up to two to three hours prior to the procedure.

2. Emergencies:

In an emergency, when a full stomach is assumed for a patient, drugs given to relieve pain should be provided at doses that preserve the patency of the upper airway and the respiratory effort. The patient should be monitored so that timely intervention can be provided if the degree of sedation is deeper than that which is intended.

D. Concurrent Medications: Cardiac, antihypertensive, steroids, and other concurrent medications may be given by mouth with a sip (15-30 milliliters) of water.

E. Equipment to be Immediately Available:

1. Oxygen
2. Oxygen saturation monitor
3. Bag and mask, oral airways, laryngoscope, endotracheal tubes
4. Suction
5. Emergency drugs necessary for cardiopulmonary resuscitation
6. EKG monitor/defibrillator
7. Blood pressure monitoring capability
8. intravenous line at the option of the responsible physician/dentist

F. Personnel:

The practitioner responsible for the treatment of the patient and/or the administration of drugs for conscious sedation shall be appropriately trained in the use of sedation and airway management. Only a physician/dentist or a registered nurse may administer drugs for conscious sedation. For conscious sedation, the minimum number of personnel shall be two: the physician/dentist and an assistant trained to monitor appropriate physiologic parameters and assist in any support or resuscitative measures required.

Registered nurses and technicians assisting the physician/dentist performing the procedure must have training in basic life support, knowledge of the effects of sedative drugs, knowledge of appropriate physiologic parameters, and should be familiar with the emergency can inventory. Documentation of competency in these areas shall be maintained in each employee's permanent personnel file. Moreover, the practitioner and all auxiliary personnel should participate in periodic reviews of emergency protocols to ensure proper function of the equipment and staff interaction.

G. Monitoring and Documentation:

1. The person evaluating the response of the patient to the drugs must Not be the person performing the procedure. His/her primary responsibility should be the monitoring of the patient.
2. During the procedure, oxygen saturation shall be continuously monitored Blood pressure, pulse rate, respiratory rate, and oxygenation saturation should be monitored and recorded as part of the permanent record to document care. Charting should be done at a minimum of 15 minute intervals; more often if the patient condition warrants (suggested document format attached).

3. During the course of conscious sedation, the patient must be responsive to physical or verbal stimuli at all times. If the patient becomes unresponsive to physical stimulation or verbal command, he/she has entered deep sedation. Such an individual should receive appropriate airway management and should be considered to be under general anesthesia, e.g. deep sedation carries the same risks as general anesthesia.
4. At no time shall a sedated patient be left unattended.

H. Guidelines for Drug Usage:

Special care should be taken to administer all drugs in small increments with adequate time to assess the level of consciousness and protective airway reflexes. Vigilance is required to avoid deep sedation with certain ultrashort acting, potent respiratory and CNS depressants. These drugs include but are not limited to methohexital, sodium thiopental, midazolam, fentanyl, and ketamine.

Nurses in GI Procedures are no longer permitted to mix drugs: this must be done on the floor and sent down to Procedures; for this reason, drugs must be ordered well enough in advance to prevent delay in starting a procedure, unless Cipro is administered. Nurses no longer need to record medication doses on the pink sheets because there should be no problem importing these doses into ProVation from ProVation RN, which saves the nurses additional effort. For two procedures, the nurse can record the drug doses separately.

I. Post Sedation and Discharge:

The practitioner performing the procedure is responsible for determining whether the patient is ready for discharge to the PACU, a hospital room or home accompanied by a responsible adult. A discharge note should be written by a physician/dentist and should include the condition of the patient at discharge using specific descriptions.

1. Outpatients: Patients will be monitored at a level commensurate with that during the procedure until such time that they are awake and alert or return to the pre-sedation level of consciousness. Patients should be able to ambulate and tolerate fluids by mouth. At this time they will be discharged from the hospital. The responsible adult will sign the Post Sedation Guidelines Discharge Instructions form acknowledging responsibility for the patient at discharge.
2. Inpatients: Disposition of inpatients will depend on the status of the patient. Conditions for leaving the procedure area are as follows:
 - a. Non-ICU inpatients will be monitored until such time that they are awake and alert or return to the pre-sedation level of consciousness. These patients may return to the floor prior to full recovery if special arrangements have been made with the physician/dentist and the nursing staff on the floor. Transportation of a sedated non-ICU inpatient should be performed by a trained individual who is BLS certified and has experience and knowledge of oxygen saturation monitoring.
 - b. ICU and other critically ill patients may be transported back to critical care areas as soon as the procedure is completed: A physician/dentist and/or registered nurse must be in attendance during transport.

The AGA Institute jointly sponsors – along with the Digestive Disease Research Foundation (DDRF) – an endoscopic sedation workshop, now in its eighth year, hosted by the New York Academy of Medicine in New York, NY, at the Mount Sinai School of Medicine. This past year’s workshop was held on Saturday, November 12, 2011.

This one-day program is designed for gastroenterologists, colorectal surgeons, GI endoscopy nurses, and GI practice administrators who wish to understand and improve the delivery of endoscopic sedation, maximize patient satisfaction with the endoscopic experience, increase efficiency in the endoscopy unit, and develop guidelines for endoscopic sedation and risk management.

GI Procedure Guidelines

1. Any drug from the pharmacy cannot be left unattended and must be locked up at all times when not in use. If drugs are on the travel cart, they must be kept in the ‘locked’ area on the side that is kept locked when the cart is not attended. The key that locks this side is the same key that locks the cart, which can be obtained from the nurse supervisor for GI Procedures. Drug samples are not to be kept anywhere in the GI Procedures area, not even in the fellows’ space. Drug samples can be kept in a locked file in the GI Medicine Clinic, a space designated for that purpose. Drug representatives, if they wish to drop off drug samples, can do so by going to the GI Medicine Clinic where their samples will be stored and locked.
2. In picking up endoscopes from procedure rooms, they must be transported in a cart covered by a towel or some other cover. **Do not** carry dirty scopes in your hands through the hallway. Additionally, no food or drink is permitted in patient care areas, which includes all of GI Procedures except for the receptionist/coding offices.
3. Material Safety Data Sheets (MSDS) are available for all applicable chemicals used in the GI Procedures area and are kept in Phyllis Frazier’s office, along with all policy manuals. Phyllis is the nurse educator clinician (NEC) for the GI Procedures Unit.
4. All MDs including staff members must know how to interpret the chemical indicator showing that sterilization has taken place for our instruments. This is indicated by the presence of dark diagonal lines on the tape strip indicator in addition to a sticker attached by Central Processing, which states “sterilized.”
5. Each MD is required and responsible for attaching endoscopic reports and path slips to specimen bottles in addition to logging the path into the log book and putting the bottles/reports in the tub so they can be picked up and taken to Pathology. **The nurses are not supposed to do this. It is each MD’s responsibility to do this.** Recently, there was an unfortunate incident in which a path specimen was lost.
6. All physicians in GI Procedures must wear their hospital ID badge.
7. Because of the volume of paper refuse in the GI Procedures Unit, please use the recycling bins, one by the copier in the back and one by the secretaries. For confidential and sensitive patient material, please use the HIPAA-designated Shred-It bins, one located by the copier, and the other in the fellows’ space. If anyone needs to contact UNC-Hospitals Recycling Office, the number is 6-5611.

8. Fellows must remember that, according to hospital conscious sedation guidelines, nurses must receive specific orders before administering any sedating drugs. It does not suffice to say “sedate lightly” or the like: a specific dose of medication must be stated. All additional doses of sedation require verbal notification during the procedure. Nurses should keep the ordering physician aware of the cumulative dose of medication received during the procedure. Patients over the age of 80 should not be given more than 0.5 mg of Versed at a time.
9. Please remember to treat the nursing staff and other staff members with courtesy and respect. In the past some nurses have complained that fellows had demeaned them, either alone or in front of other staff. We are trying in particular to retain good nurses in our unit. Please work together as a team for the common good of the patient.
10. ALL VETERAN’S ADMINISTRATION PATIENTS HERE FOR A SCREENING COLONOSCOPY DO NOT GET REFERRED TO UNC SURGEONS; THEY SHOULD RETURN TO THE VA HOSPITAL.

CTC Scheduling for Failed Colonoscopies

As of 4/29/11, Radiology put into effect its CT colonography protocol. Patients can be scheduled on Wednesday, Thursday, and Friday. Yolanda Dunmore, manager in radiology, 6-4292, can fax you a scheduling form for CTC, so that in the event of a failed colonoscopy, you can schedule a CTC for completion.

GI PRE-PROCEDURE ORDERS

Procedure (with type-in indication)

Colonoscopy

EGD

Enteroscopy

ERCP

EUS

Flexible Sigmoidoscopy

Ileoscopy

PEG/PEJ

Nursing:

-Start clear liquid diet now

-NPO after midnight (except for bowel prep)

-Hold aspirin

-Hold Clopidogrel

-Hold enoxaparin/heparin after midnight

-Place NGT, call intern on-call to verify placement and to begin bowel prep after chest x-ray completed.

-Patient MUST have functional I.V. access prior to departure to GI procedures. Please verify and if any difficulty with i.v. please contact Housestaff.

Meds:

Ampicillin 2 gram i.v. on-call to GI procedures
 Cefazolin 1 gram i.v. on-call to GI procedures
 Clindamycin 600mg i.v. on-call to GI procedures
 Vancomycin 1g i.v. start 1 hour before GI procedure

Polyethylene Glycol-electrolyte solution - 240 mL (8 oz) every 10 minutes, until 4 L are consumed or the rectal effluent is clear; rapid drinking of each portion is preferred to drinking small amounts continuously. Call intern on-call if patient has not taken ½ of bottle by 2 hrs and rectal effluent is has not cleared.

Radiology:

Chest radiograph – verify NGT placement

Portable chest radiograph – verify NGT placement

PRE-LIVER BX

Nursing:

- NPO
- Please obtain Jamshidi soft tissue biopsy kit for liver biopsy and place to bedside.

Labs:

- PT, PTT (drop down, prob. nurse draw if in CDU)
- CBC (drop down, prob. nurse draw if in CDU)

POST-LIVER BX

- NPO x 2hrs
- Clear liquids x 4hrs, then resume prior diet as tolerated
- Vital signs q 15minutes x 4, q 30 minutes x 4, then q 1 hour x 4
- Orthostatic vital signs prior to discharge unless patient is staying overnight. Then check orthostatics in the a.m.
- Right lateral decubitus position x 2 hours after procedure then bed rest x 4hrs.
- Place PIV with NS flushes q 8hrs.

GI POST-PROCEDURE

Nursing:

Post-PEG/PEJ

- NPO except for medications for 4 hours.
- In 4 hours if bowel sounds are normal and patient is afebrile, begin feeding and tube flushes as per Nutrition Service Recommendation
- Site care twice daily:
 - a. Cleanse wound with half-strength hydrogen peroxide.
 - b. Rinse with normal saline and dry.

- Contact UNC Social Work and Continuity of Care for patient and family teaching and discharge planning.
- Send product insert and nursing instruction sheets with patient at time of discharge.
- If the P.E.G/P.E.J tube is accidentally removed within 2 weeks of today, contact the adult GI Fellow on call (919) 966-4131 or 123-7010 immediately. Do not attempt to place a Foley or other tube into the site because the stomach may not be as adherent to the abdominal wall and the tube may enter the peritoneum.

Post-Sphincterotomy

- Check vital signs every 30 minutes x 4, then each 1 hr x 4
- Clear liquid diet for 24hrs.
- Bed rest with bathroom privileges for 6hrs then up ad lib.
- Call H.O. for sever pain or temp over 38.8C
- Have H.O. notify GI fellow of any complications.

Labs:

- CBC (there would be a drop down time option here).

STEPS FOR DOING A PROCEDURE

- Do the procedure;
- Consent the next patient if this has not already been done;
- Write and print report/discharge instructions/pathology document;
- Attach both the pathology document (path slip) *and* the path report to the path jar and drop it in the path tub;
- Talk to the patient and his/her driver and give the patient a copy of his/her report;
- Put two copies of the discharge instructions on the patient's bed;
- Answer a page, make a call, go to the bathroom, etc.;
- Begin another procedure.

Assistance for Spanish Speakers Having GI Procedures

The ASGE web site contains a page with patient information about GI procedures, in Spanish: http://www.asge.org/gui/patient/sp_index.asp. These printable forms provide patient education over and above that which is listed in the UNC GI consent forms written in Spanish. The fellow is encouraged to use this service whenever appropriate and to email or fax the information to any outside clinic seeing Spanish-speaking patients. Tammy Jones, nurse in the GI Clinic, is supposed to have bookmarked this site on computers in the clinic. One must be careful when deciding the appropriateness of the form to use because there are no English headings, which may be troublesome to non-Spanish speaking persons.

Dr. Douglas Morgan, pager 216-4783, phone 3-8104, douglas_morgan@med.unc.edu is fluent in Spanish and interacts with many of our Hispanic patients in the GI Procedures Area. If he cannot be located, UNC Hospital Interpreter Services can be paged at 347-1877.

Eye shields: We have stocked a new type of eye shield in GI Procedures, with which all seven rooms are equipped. Previous versions of disposable eye shields have been reported as uncomfortable, difficult to see through, and prone to fogging readily. The new shields appear to function much

better. With the availability of these shields, everyone participating in a procedure is expected to wear eye protection.

GI Procedure Equipment and Inventory

Equipment for video capsule endoscopy (VCE) arrived on January 6, 2003, which the hospital installed in February of 2003. If you have referrals for VCE studies, please forward them to Dr. Doug Morgan via email, douglas_morgan@med.unc.edu. To see an interesting video clip of this new capsule device, go to <http://www.rfnorika.com/kindex1.html> and check the English menu. You may also check the ASGE site at <http://www.asge.org/gui/patient/>, which provides an overview of capsule endoscopy "Understanding Capsule Endoscopy." There is also a project called DAVE (digital advanced video endoscopy) that you may want to read about by going to www.google.com and specifically <http://dave1.mgh.harvard.edu/index.cfm>, an excellent site containing an incredible wealth of information. To visit the Visible Human Journal of Endoscopy, visit <http://www.vhjo.org>. A terrific endoscopic video atlas can be found at <http://www.gastrointestinalatlas.com/index.html>.

Our foreign body retrieval kit contains the following:

- 1 large biliary stone basket
- 1 large Roth retrieval net
- 1 small Roth retrieval net
- 1 large rat tooth forceps
- 1 small rat tooth forceps
- 1 large snare
- 1 small snare
- 1 Steigman-Goff Ligator
- 1 Steigman-Goff overtube

Sengstaken tubes, more commonly known as Minnesota tubes, are for single use only. If you use one, please let the nurse manager know. We also have new overtubes in stock, which come in two diameters, such that you need to match the scope size (see outside of overtube package) to the tube. They are long enough to go easily into the stomach. The distal tip is soft and tapered so that there is no gap between the scope and the overtube, as long as you select the correct tube size (gap = blame for perforations). There is also an obturator to provide additional safety. These are not cheap (\$150 each) and cannot be reused. Therefore, you should not use one of these if you think that one of the older tubes will suffice. These are kept in the nurse manager's office. If you need one after hours, you can ask security to open the office: look for a long skinny cardboard box. After the procedure, leave a copy of the report in the manager's mailbox, which is needed to arrange for billing.

We now have in stock the devices needed to perform Russell gastrostomy and/or gastrojejunostomy. Essentially this is the procedure that radiologists use, except we do it with endoscopic guidance. In some cases, it may be unwise to drag a large bolus through the upper GI tract, particularly in the presence of severe esophageal stenosis, recent perforation, severe esophagitis, and the like. Also, in patients with head and neck malignancies, there is a potential to seed the gastrostomy tract with cancer. The Russell method of gastrostomy can be performed with any caliber of scope, as endoscopy is only needed to visualize the puncture site.

We have been performing endoscopic gastrojejunostomies on women with hyperemesis gravidarum, with good results. Previously, these patients had been seen in VIR, but they have decided to refer all

such cases to GI procedures instead to avoid radiation exposure to the fetus. The G-J tubes in these patients have not been displaced by emesis, though clogging has been an issue.

Historically, radiology has handled most of the requests for placement of G-J tubes in this hospital since they seem to have had better results than endoscopically placed G-J tubes. However, this is no longer the case since we have better G-J devices as well as the potential to place G-J tubes similar to the ones used in VIR.

As of 6/15/07, we have proposed to remove hot biopsy forceps from our inventory in GI procedures. The ASGE recommends that hot biopsy forceps NOT be used for polyps over 5 mm in diameter, as they often leave residual neoplasia and because they carry a risk of electrocautery complications, especially in regard to post-polypectomy bleeding. For polyps 5 mm and under, cold forceps and mini-snare may do a better job, with less risk of complications. Our preference has been to use jumbo biopsy forceps, which easily and rapidly remove small polyps in their entirety. Therefore, hot forceps should be removed from our inventory to discourage their use, and, in their place, jumbo forceps should be used liberally in the colon for small polyps.

In the upper tract, large capacity forceps (e.g., for Barrett's survey and duodenal biopsies) should be used, but NOT the jumbo forceps, as these only fit through the larger channel size of the colonoscope or therapeutic upper scope.

ERCPs

Per Dr. Ian Grimm, Director of the GI Procedures Unit, we are supposed to record fluoroscopic time for all ERCPs. Not only should the nurses be recording this in their notes, but, as a backup, we also need to put it in our procedure letters. Therefore, try to get into the habit of writing it down on a 'cheat sheet' at the end of each ERCP. This is a requirement for all fluoroscopic use.

Because of administration of droperidol, outpatients scheduled to undergo routine ERCPs should arrive early for a pre-procedural EKG. For inpatients, an EKG should be ordered the night before the ERCP. If an outpatient is ambulatory, they can be given an order requisition that they can take to pre-care, where the EKG can be performed. (This takes about 20 minutes, and the results are sent with the patient. The patient is not required to check-in or pre-register in pre-care.) If an outpatient is not ambulatory, an EKG tech can be paged and an EKG ordered as "expedite" or "stat," and the tech comes to the patient and performs the EKG. Unfortunately, an EKG machine cannot be kept in GI Procedures for our use because Cardiology controls all of the EKGs done and read at UNC-Hospitals.

Post ERCPs

After each procedure, ProVation software prints out patient instructions, including recommendations made in your report. Post-ERCP instructions can be modified according to our needs. ProVation provides its own standard post-ERCP instructions.

Explicit instructions about the need for stent exchange/removal, x-rays, etc. **must** be listed in the procedure recommendations, as this insures that the patient will receive a copy of your advice.

A stent is a plastic or metal tube that is placed in order to improve drainage from the pancreatic duct or bile duct. Some are permanent, whereas others need to be removed or replaced. Some stents are intended to fall out on their own. The patient should receive clear instructions about the need to

return for stent replacement or removal. A clogged stent can result in abdominal pain, fever, chills or other problems. If a patient develops any of these symptoms and has a stent in place, s/he must seek medical attention immediately or contact the physician who placed the stent for further advice.

All stent patients should have either of the following:

- A clinic follow-up visit scheduled;
- A follow-up ERCP scheduled;
- A follow-up visit scheduled with his/her primary MD who should receive a letter and accept responsibility for the stent (e.g., a terminal patient with a metal stent in situ).
- If none of the aforementioned follow-up options is available, the patient should be scheduled a return visit to our Pancreaticobiliary Clinic for follow up.

All patients requiring stent placement must be tracked by keeping a log on Excel in regard to “no shows” or potential cases lost to follow up.

All ERCP patients have a risk of pancreatitis developing after the procedure. Overall, about 7% of patients may develop this side effect. Pancreatitis usually causes severe upper abdominal pain, often with nausea and vomiting. Most cases develop within 12 to 24 hours after the procedure. Pancreatitis often requires hospitalization; if one develops abdominal pain following the ERCP, medical attention should be sought immediately.

Avoiding large meals and fatty foods immediately after ERCP may lower the risk of pancreatitis. Therefore, patients should have clear liquids only for 8 hours after the ERCP. If after 8 hours the patient has no pain and a good appetite, s/he may have a light snack with low fat foods. If s/he feels fine the morning after the ERCP, the patient may resume his or her usual diet.

A new policy has been adopted covering radiation exposure to pregnant women, as might occur during an ERCP: All pregnant women about to undergo a radiologic procedure require consent, administered by a radiologist. Contact the staff in the fluoroscopy area for instructions on how to do this.

Per the AGA coding seminar of 4/04, AMA has clarified the issue of multiple placement of stents. If multiple stents are inserted into different areas of the biliary system, for example, one in the bile duct and one in the pancreatic duct, more than one stent can be billed if one is placed in the bile duct and the other in the pancreatic duct. However, if more than one stent is placed in the SAME duct, only one CPT code is billable. AMA further determined that, in terms of billing multiple stent insertions, the rule for ERCPs is also applied to EGDs. For an ERCP, the physician performing the procedure can code for interpretation of fluoroscopy *only if* s/he actually did the interpretation and not a radiologist.

Regarding fluoroscopy CPT codes – when a physician is using fluoroscopy for general ERCP image viewing, the correct CPT code is 76000. The CPT code 76003 for fluoroscopic guidance for needle placement (e.g., aspiration, biopsy, injection, localization device) has been discontinued and replaced with CPT code 77002. According to AIS, we charge \$70.00 for this particular CPT code. However, since films are sent to radiology for interpretation in virtually all ERCPs, we would not use 76000 to bill for our ERCP cases, with the exception of a cystgastrostomy or if the physician were to interpret the images him or herself. We can use 76000 if no permanent films are made and no radiologist is present. For us, 76000 is used almost exclusively for non-ERCP cases. Also, needle placements are almost always guided by EUS – we might use fluoro for needle placement during a cystgastrostomy

procedure, but there are not too many other cases when we would use fluoro for a needle placement.

With our new fluoro suite, however, we can use CPT code 76000. Since ERCP films are sent electronically to radiology for reading and subsequent archiving in PACS, for which radiology collects the interpretation fee. At present, this new room does not have a link to PACS. Permanent images are instead stored on cartridges, which need to be loaded onto PACS in the radiology department. If a film is submitted this way, radiology, of course, gets paid. Also, this way, someone has to transport the large cassettes back and forth from the radiology fluoro area. But, if we use fluoro and do not submit permanent films for interpretation, then we can – and do bill – and collect, in which case the CPT code 76000 can be added manually to the ProVation report. Therefore, most of the cases done in this new room can and should be billed this way, unless permanent documentation of the findings is desired.

BILIARY ROTATION

ROTATION GOALS

Biliary tract diseases

A major goal of the training in biliary tract diseases should be to develop highly skilled consultants who can provide state-of-the-art care to patients with complex biliary tract diseases. These highly trained specialists should be aware of the advantages and disadvantages of available options involving the diagnosis and therapy of biliary diseases and of potential complications; if complications occur, the specialists should be in a position to manage them. To accomplish this goal, trainees should do the following:

1. Become acquainted with varied presentations of biliary tract diseases and have detailed knowledge about all aspects of biliary diseases.
2. Acquire competency in the decision-making process involving the appropriate choice of diagnostic procedures, their timing, and their sequence.
3. Establish proficiency in diagnostic and therapeutic procedures involving biliary tract diseases and acquire the ability to perform them safely, successfully, and expeditiously.
4. Appreciate the advantages and disadvantages of radiological and endoscopic procedures and be able to balance the risks and benefits of these procedures for patients (refer to Task Forces on Training in Gastrointestinal Endoscopy and Training in Gastrointestinal Radiology).
5. Understand the importance of teamwork, which involves close collaboration with radiologists, surgeons, and hepatologists.

Responsibilities of the Biliary Fellow

1. Consultation on patients with biliary tract problems, both on the inpatient service and in the outpatient setting. You may be contacted by the team taking care of the patient, the GI consult team, and/or directly from the inside or outside physician requesting a biliary consultation or procedure. All patients who must undergo an ERCP require a consultation.

2. Perform endoscopic biliary procedures including ERCP/ERCP with manometry as well as therapeutic procedures including stent placement, sphincterotomy, and stone extraction. The threshold for establishing competence per the American Society of Gastrointestinal Endoscopy is 200 ERCPs, which should include 40 sphincterotomies and ten stent placements.
3. To the extent that it is safe and reasonable, you may avoid scheduling ERCPs during your clinic time. However, if it is more efficient and/or more cost effective or in the patient's best interest, ERCPs will be done when you are in clinic. In this case, the designated alternate biliary fellow will be asked to participate in the ERCP.
4. Appropriate follow up of those patients who have had biliary procedures in the hospital once admitted or as an outpatient. Follow up includes clear communication with the referring physician(s), both verbally and in written form. If the patient is to follow up in clinic, it would be helpful for the consult fellow to email our Appointment Center (csgi@med.unc.edu) the name, medical record number and appropriate physician (in most cases you as the fellow) of those patients for us to follow up in clinic so that when the ward clerk or intern calls this can be taken care of efficiently. If you name a physician other than yourself, please cc that individual as well.
5. Assist in the endoscopy unit to keep procedures on schedule. When you are not actively involved in a biliary procedure or consultation, you should be in the unit assisting with cases and with the flow of the unit.

Pancreatic Consult Service

Beginning in March of 2011, Drs. Ian Grimm and Christopher Rupp developed a consult service for patients with severe pancreatitis. This is an excellent opportunity to improve teaching in biliary and pancreatic disease, especially if combined with the idea that second-year fellows on our biliary rotation tend to do principally consultative work rather than endoscopy. Now that the service has been established, we would like to use this as much for the education of our fellows as for service.

The consult pager number is 123-7370. All consults are routed to Dr. Rupp's service for evaluation of patients, with notification to the necessary service (e.g., family practice, hospitalist, medicine & surgery). One area of concern has been that a consult fellow or attending has received consults to the ICU as much as 5 days after the patient is admitted, when they are, by that time, in shock with multi-organ failure. Thus, effort has been concentrated on the MICU to avoid such delays, to some extent due to the housestaff not recognizing the seriousness of the complication early on.

We might consider rounding 3 times a week with the surgeons on any patients in house with severe or complicated pancreatitis. Pancreas cases could be presented at our Tuesday afternoon conference, perhaps with review of radiographs, if indicated. Please contact Dr. Christopher Rupp at 6-8436, email christopher_rupp@med.unc.edu.

Advanced Fellow EUS Policy

Drs. Grimm and Gangarosa have formulated the following policy regarding EUS when we have an advanced endoscopy fellow. As our EUS volume grows, we expect that there will be more than enough cases for one fellow to learn from, especially rectal and esophageal cases, and simple submucosal lesions.

For many cases, it is reasonable for both the advanced fellow and third-year fellow to participate in and learn from a given procedure. Much of the learning comes from viewing the EUS image, and not from driving the scope. Both are encouraged to attend a case if they do not have other obligations. There will often be opportunity for both fellows to drive the scope for some portion of the exam. In general, the advanced fellow will start the case, have priority for learning opportunities, and be responsible for pre- and post-care.

In the event the advanced fellow is doing an ERCP at the time that a EUS is scheduled, the biliary fellow will be asked to do the EUS procedure. The biliary fellow is welcome to do EUS cases generated on his or her own initiative, and any cases scheduled when the advanced fellow is not available in the unit.

The advanced fellow is asked to notify us of the times that s/he will be in clinic, attending in procedures, on interviews, on vacation, or otherwise unavailable to do EUS cases.

All EUS cases for cancer patients should be scheduled at the earliest possible opportunity, based on the schedule and the patient's preferences. If a fellow is not available at this earliest opportunity, then Dr. Grimm or Gangarosa will perform the procedure without a fellow.

Tracking Biliary Cases

Dr. Craig Cender, former fellow, implemented two group lists on WebCIS 2.0 in 4/04 to be used by biliary staff. One, entitled 'biliary', is intended for active biliary cases, predominantly inpatient (although newly scheduled or recent outpatient procedures could certainly be added to this list), for easy access. The second and more essential one is entitled 'biliary stent' in order to track any indwelling stents. Although Dr. Cender created an Excel spreadsheet for this, a list on WebCIS seems to offer numerous advantages, not the least of which is that anyone can access it at any time and from any computer. All of these are on the group list and can be subscribed to by each individual. Dr. Cender implemented these two group lists primarily to minimize the perpetual problem with stent tracking since there appears to be no way to track stents in ProVation.

Related Conferences

One senior fellow and/or advanced endoscopy fellow is able to attend the "Rocky Mountain Pancreaticobiliary Fellow's Program" held at the University of Colorado Health Sciences Center in Aurora, CO. This includes didactic lectures on the diagnosis and endoscopic management of pancreatic and biliary disorders. The hands-on ERCP training utilizes pig models and state-of-the-art techniques with fluoroscopic guidance to familiarize the trainee with the most up-to-date biliary devices and techniques. Additionally, registered participants have the opportunity to attend the Rocky Mountain Interventional Endoscopy course immediately following the Fellow's program, held this year on February 11-13, 2010. This outstanding opportunity is made possible by an unrestricted educational grant from Boston Scientific Corporation. A scholarship in the amount of \$750 is provided to the fellowship training program through the University of Colorado to help defray the cost of travel, meals and registration fees for the Fellow's Course and the Rocky Mountain Interventional Endoscopy Course. Registered participants are entitled to three nights of free hotel accommodations and shuttle service between the hotel and conference location. To qualify for this scholarship, the fellow must first submit a completed registration form to both courses with a \$250 registration fee enclosed, which covers the registration for both courses. Because of limited funding, only 30 fellows across the country are offered this scholarship. Registrations are accepted on a first-come, first-served basis. Only one senior fellow can be selected

to attend from each training program. For additional information, please contact Colorado Event Organizers at 303-830-6850 or events@ceo-events.com. The CME course program includes eight hours of lectures and live case demonstrations on Thursday (2/11) and Friday (2/12) and hands-on workshops on Saturday (2/13) from 8:00 a.m. to 12:00 noon. This advanced endoscopy workshop allows participants to gain hands-on exposure to new and/or advanced endoscopy techniques and devices, utilizing a combination of animal models and fluoroscopy for training. Participants select one of three modules: 1) endoscopic retrograde cholangiopancreatography (ERCP), 2) double-balloon enteroscopy and enteral stenting, 3) endoscopic mucosal resection, closure and hemostasis. Registration for this specialized workshop is restricted to practicing GI physicians and senior GI fellows. Because of the hands-on nature of the course, class size is limited, and individuals are accepted on a first-come basis. Learning objectives for the Rocky Mountain Course in Interventional Endoscopy include:

1. Describe key advances in interventional endoscopy.
2. Select appropriate patients and assess the risks of endoscopic intervention.
3. Demonstrate familiarity with a variety of endoscopic devices and techniques for treating gastrointestinal and pancreaticobiliary disorders.
4. Describe impact of emerging technology on endoscopic practice.

This past year, senior and advanced fellows have been invited to attend the endoscopy course, “ERCP A-to-Z, 2009, A Live Case Course,” on Thursday and Friday, September 10 and 11, 2009 and the “Hepatology 2009, State-of-the-Art Course” on Friday and Saturday, September 11 and 12, 2009. The course is held at the Marriott Hotel, directly attached to Mayo facilities in Rochester, MN from 7:30 AM to 5 PM each day. There are a number of complimentary spaces for fellows for whom hotel room costs are covered during the three days of the course (Weds PM, Thurs PM and Fri PM). Personal or local resources are responsible for travel. Any second- or preferably third-year and advanced fellow can forward a note of interest and arrange registration with Jowelle Henning by emailing her at henning.jowelle@mayo.edu, by telephone at 507-266-0339, or by mail at 200 First Street SW, Mayo 1900-1, Rochester, MN 55905. The fax number is 507-266-5205.

This past year, the Harvard Medical School Department of Continuing Education offered ‘Endoscopic Ultrasonography *Live!*’ on November 6-8, 2009 at the Fairmont Copley Plaza Hotel in Boston, MA, with William R. Brugge, M.D., serving as course director. This three-day weekend course (Friday – Sunday) featured live broadcasts from Massachusetts General Hospital, lectures by noted authorities, and hands-on workshops. For the first time, participants had the opportunity to experience a Skills Assessment and Testing (SAT) program in EUS. Included was a special lecture and demonstration on EUS-guided tumor ablation therapy. To view the course description, program, faculty, and to register online, visit: www.cme.hms.harvard.edu/courses/endoscopic2009 or email Jurate Aukstikalnis at jaukstikalnis@partners.org.

GI BLEEDER CONSULTATION POLICY

Our policy regarding GI bleeders (upper and lower) between 8 a.m. and 5 p.m.:

The consult fellow takes the call. Either over the phone or after seeing the patient s/he decides whether the consult service or the liver service will do the consult and endoscopy. The liver service will handle the case if the patient: 1) has or probably has portal hypertension, 2) is likely to be transferred to the liver inpatient service or be followed in the liver clinic, 3) is followed in one of the liver clinics, 4) is listed for liver transplantation, or 5) is post liver transplant. If the patient meets any of these criteria, the consult fellow contacts

the liver fellow to take the consult, and the consult fellow lets the requesting team know that the liver service will do the consult and any needed endoscopy.

Our policy regarding GI bleeders (upper and lower) between 5 p.m. and 8 a.m.:

The consult fellow takes all calls. After evaluating the patient in person the fellow discusses the patient by phone with either the liver attending (if the patient meets any of the five criteria noted above) or the consult attending (for all others). The fellow's decision about which attending is responsible is final and may not be overturned by the attending called. A decision is made regarding the necessity and timing of any endoscopy. The liver attending may decide to do the endoscopy procedure with the fellow.

The fellow prepares for the endoscopy and notifies the endoscopy attending on call (unless the liver attending prefers to precept the case). The endoscopy attending on call DOES NOT have the prerogative of changing the plan or the time of endoscopy. If s/he disagrees with the plan or timing of the endoscopy, s/he must discuss this matter with the consult or liver attending who made the decision and whose ultimate decision is final.

Night and Weekend Endoscopic Care

Care of the endoscopes is extremely important. If they break it means that the endoscope is not available for use which can really affect our ability to do procedures. Treat these instruments with care and they will be good to you.

Basic Care:

1. Do not bend the endoscopes in odd ways as the fibers will become damaged.
2. Do not let the patients bite the endoscope. Remember an uncooperative patient is a contraindication to endoscopy.
3. Do not contaminate the contents of drawers by putting dirty-gloved hand in drawers. Have someone else retrieve the object (s) you want or remove your dirty gloves.

Immediately after procedure:

- Suction water through the biopsy channel
- Blow air and water through the A/W channel

In unit:

- Put valves, bite block, colonoscope/sigmoidoscope tip cover and irrigating syringe in soap solution sink.
- Suction soap solution through biopsy channel with biopsy port cleaning adapter attached.
- Wash control head and insertion tube with washcloth.
- Brush biopsy channel in both directions, through insertion tube and light guide connector channel, then suction more soap solution (200-300 mls)
- Put insertion tip and biopsy channel adapter under running water and suction it through so that soap residue will not dry in channel.
- Leave endoscope on "dirty" towel to the left of the sink.
- Before re-setting up emergency cart wipe clean with alcohol-wet washcloth
- Suction soap through both biopsy ports on 2T10 and 2T20 using the biopsy cleaning adapters.

- Flush back irrigating channel on 2T10 with short adapter — it clogs with organic material easily. (2T20 does not have this channel.)
- Heat probe: Apply water protection cap **before** immersing in soap solution. Flush with washing tube and syringe hanging in plastic bag above sink.
- Sclerotherapy injectors: Cut off needle and place in sharps container. Discard the rest of the injector.

Other:

- **LEAKAGE TEST** all endoscopes prior to cleaning. With leakage tester in place and under pressure suction soap solution and watch exterior then leave on counter with note. The repair cost will be several hundred dollars vs. several thousand dollars....

Night and Weekend Emergency Procedures

- Return all equipment and accessories to unit. Endoscope parts, water bottles, alcohol bottles, oximeter parts, bite blocks and irrigating syringes have been lost.
- Have every procedure entered into the SMS system either before or after you do the procedure.
- Complete the charge sheet, including accessories used (eg. heat probe, sclerotherapy injector, retrieval forceps, etc.) and give to GI procedures secretary.
- Therapeutic ERCP: There is no formal “on call” system for nurses. There is a list in the nurse’s station — the last person on the list should be the last one contacted — s/he was the last person to actually come in for a late procedure.
- Holiday on call for therapeutic ERCP’s and scope disinfection is rotated through the nursing staff and is designated on the schedule at the key box.
- If too many dirty endoscopes accumulate on a weekend, contact the on-call tech to disinfect them.
- JCAHO/UNCH requires oximetry monitoring and pre-, intra- and post-procedure vital signs documentation for patients receiving conscious sedation. ICU nurses should fulfill this requirement. To do procedures on other units you must call the nursing supervisor and try to arrange nursing help – if not available the patient must be transported to an ICU to do the procedure.
- OSHA’s bloodborne pathogens regulations require that you wear gown, gloves, mask, and eye protection for all procedures and plastic apron and shoe covers prn. Supplies are above the Travel Cart in the unit and/or on the emergency cart.
- Over-tube, protector hoods and retrieval accessories are on the peg-board in the supply room.

ON CALL – TRAVEL CART INSTRUCTIONS

1. Call UNIT-ED

- a. Insure pt can give consent; or # on chart, ask RN to attempt contact. Instruct them not to leave bedside.
- b. Ask RN to clear room of excess chairs for Cart or move to a larger room.
- c. Ask RN to suction (will need 2, one for pt, one for procedure); draw up Versed 5mg, fentanyl 100mcg.
- d. IF UGIB, consider erythromycin 250mg iv x 1 or begin octreotide GTT if suspected variceal bleed.

2. Check Cart

- a. Take a moment to consider the case you will be doing, what you think you will find (DDx), and what you may therefore need.
- b. Endoscope, consent papers (also on web site, pw is UNCGI).
- c. Bite block, NS, syringe, water retainer, green coats, towels, etc.
- d. Code Blue present.
- e. Retrieve Foreign Body kit if necessary.
- f. If suspected variceal bleed, grab Minnesota kit (may need to order from central supply).
- g. Check banding equipment present (six shooter), lidocaine swallow, epinephrine, injection needle, extra endoscope knobs, clips, cautery-bipolar probe present.
- h. Q140GIF or T140 (especially if you need a lot of suction) for upper, CFQL for colon.

3. ProVation

- a. Turn on computer once cart plugged in.
- b. Click "mobile" icon.
- c. Sign in: giproc.
- d. Sign in again.
- e. Click 'Procedure Documentation'.
- f. Click 'Enter Note for Unlisted Pt'.
- g. Click 'Add PT' (skip this window unless pt has had prior procedure, then locate by MRN with check digit preceded by four 0's).
- h. Enter pt ID # (MRN # with check digit preceded by four 0's).
- i. Enter last name, first name, middle only.
- j. Click OK.
- k. Enter acct number (smaller number on stamp at bottom with lots of preceding 0's) and enter dates, save account; select account and enter locations, staff, scope number, etc.

- l. Initiate note; click capture and insure camera is working.
 - m. If camera is not working, check connections.
 - n. After case, complete note. Turn off computer. In GI unit, hook up blue port. Turn on computer, sign on again, click 'upload', sign on again, click 'upload'. Once complete, sign on to one of the regular computers and print out note.
 - o. Tube note to proper unit or drop off.
4. If suction is not working, check that it is on.
 5. If using cautery, insure NS is used and not H2O.

FELLOWS' NIGHT AND WEEKEND ON-CALL SCHEDULE

Generally third-year fellows are responsible for coordinating and drawing up our fellows' night and weekend on-call schedule. In the past, if there has been more than one third-year fellow, those fellows have divided the year up into monthly blocks for which they are responsible, the number of blocks dependent upon the number of third-year fellows. Fellows can switch among each other as long as it is agreed upon mutually and service is paid back as promised. If any planned away time involves a change in the night call schedule, the fellow must also inform the hospital operators of the change.

Per a meeting that Dr. Sandler had with Dr. Isaacs and fellows in June of 2003, Dr. Sandler reiterates the requirement that night and weekend call must be shared equally by all clinical fellows. We expect that holidays and long weekends such as Labor Day and Memorial Day are shared equally among all of the clinical fellows. Assigning first-year fellows more coverage is not acceptable. We do not foster a hierarchical system in this regard and desire to have a program where all clinical fellows, regardless of seniority, share the work for the common good.

The on-call fellow takes first call with backup by the biliary attending. If the biliary fellow chooses to come in for the procedure s/he may do so, but this kind of case is infrequent. Since the on-call fellow takes the first call, and since coming in is discretionary for the biliary fellow, credit is not given for biliary call.

This year, Dr. Brock Miller coordinates the on-call schedule. The second- and third-year (upper level) fellows are on back-up call for the first two months to support the first-year fellows on cases involving endoscopy during night and weekends.

Because our fellows do not have in-house call, no call rooms are assigned to GI. However, call rooms are located on hospital floors.

Please note that there is a 'transport nurse' who can be called to help sedate for on-call procedures. If you look up TRANSPORT in the paging directory, the listing comes up.

RESPONSIBILITIES OF THE ENDOSCOPY FELLOW

Goals and Objectives of Endoscopy Rotation

1. Develop the cognitive ability to recommend specific endoscopic procedures based on consultation, consideration of specific indications, contraindications, and diagnostic-therapeutic alternatives.
2. Perform the technical aspects of certain procedures safely, completely, and in a timely fashion.
3. Interpret endoscopic findings correctly.
4. Understand endoscopic anatomy.
5. Integrate endoscopic findings or therapy into patient management plans.
6. Understand risk factors; recognize and manage complications.
7. Recognize personal and procedural limits and know when to request assistance.

Endoscopic Education

All fellows beginning clinic rotations must engage in basic didactic experience in endoscopy that is required before any new trainee can begin to endoscope patients, per Drs. Grimm and Farrell. Surgery residents rotating in endoscopy need to provide evidence of having completed certain portions of the simulator module before appearing in the endoscopy unit. Incoming clinical fellows should complete so many hours of simulator module training before beginning endoscopic work. Our Simulator Unit is located in 1037A Burnett-Womack, open 8 AM to 5 PM M-F. Jim Barrick, BA, NREMT-P, is our human patient simulator coordinator, affiliated with the Office of Educational Development (OED) in our Clinical Skills Center (CSC). His phone # is 3-0521, email JBarrick@med.unc.edu, web site www.med.unc.edu/csc.

In addition to initial simulator training, new clinical fellows meet with the senior fellow and are given an introduction to endoscopy, conscious sedation and airway management, anesthesia/Malampati, and travel cart instructions. The first 4 sessions of our core curriculum conference in July are devoted to a) principles of conscious sedation; b) principles of endoscopy and mucosal sampling; c) principles of management of upper GI hemorrhage (variceal and non-variceal); d) principles of management of lower GI hemorrhage. During subsequent didactic sessions throughout the year, other endoscopic topics are presented, including EUS, Olympus inservice on 180 scopes, and VCE. Third-year and advanced fellows are permitted to purchase up to \$500 for ERCP/EUS textbooks. Dr. Grimm has a DVD on colonoscopy techniques, with a companion DVD on polypectomy techniques. This is an excellent teaching tool, and anyone who does colonoscopy should utilize it, as there is something for everyone to learn, even for the most experienced operator. Dr. Grimm also keeps a library of 70 AGSE tapes on hand, which a fellow can borrow. Fellows are strongly urged to utilize the GESAP (Gastrointestinal Endoscopy Self-Assessment Program). This program comes highly recommended. Please speak with Dr. Isaacs about this learning opportunity.

First-year clinical fellows are encouraged to attend the ASGE first-year fellows' endoscopy course (highly recommended), which is held all 5 weekends (Sat-Sun) during the month of August (it is held the last Sat-Sun of July if there are only 4 weekends in August) at the ASGE state-of-the-art IT Center in Oak Brook, IL. Spaces go very quickly due to the increasing popularity of this course.

We also request that fellows – as part of their training – volunteer to give brief talks at the Thursday morning nursing meeting within the 8-9 AM slot. Topics can be basic but should be of interest or benefit to the nursing staff. You can let Dr. Grimm or the nurse supervisor know if you are interested in doing this.

For a quick reference to our comprehensive manual of GI procedures, go to

http://books.google.com/books?id=-3ImxPXcAhUC&dq=douglas+drossman&printsec=frontcover&source=web&ots=PsLxesEBPC&sig=8Gx6uRIAD77Z9OCaF3Efr5q74_k#PPR7,M1

Specific Issues

1. At any given time in the Procedures Unit, one or two fellows are responsible for outpatient endoscopy cases. Generally a third-year fellow is responsible for biliary endoscopy. The biliary fellow also assists with routine endoscopy whenever a biliary case is not in progress. Outpatient endoscopy cases consist of both upper and lower endoscopic procedures.
2. Fellows are responsible for evaluating patients for the procedures prior to arrival to determine certain indications, if any, and by physical exam on the day of the procedure. Review requisitions and schedule sheet at least two days pre-procedure. Contact referral MD and/or patient for questions about the appropriateness of the procedure (i.e., flexible sigmoidoscopy for hemocult-positive stool, colonoscopy for rectal bleeding) or about safety issues (if a patient is diabetic, s/he must hold an oral agent and/or use ½ dose of insulin on the day of the procedure; if a patient is on an anticoagulant, s/he needs prophylactic antibiotics). Try to identify problems early in the day so that the appropriate referring physician can be reached and preps can be stopped before they are begun.
 - The day before the procedure distribute all requisitions into appropriate slots. Requisitions should stay in these slots until the case is done so they will be available for whoever does the case. When the case is done, staple the requisition to your copy of the report.
 - The afternoon/evening before the procedure, review patient information on the CIS.
 - When the patient arrives in GI Procedures, a brief examination of the heart, lungs, and neurologic status must be performed. If a history has not been done within the last thirty days, a brief history and physical should be recorded on the record sheet by you and the attending.
 - Any contraindications should be posted on Physician Order Entry (POE) to notify Housestaff and nurses on the floor for inpatient procedures so that there is intercommunication between housestaff and fellows and nurses on the floor and nurses in GI Procedures. In one instance, a patient was not to be administered any medication between the AM and the procedure in the PM; the nurse, unaware of this, gave the patient medication before the procedure, which led to complications.
3. Endoscopy begins at 8:00 a.m. sharp on Mondays, Tuesdays, and Fridays and at 9:00 a.m. on Wednesdays and Thursdays. The fellow is expected to be in the Procedures Unit 15 minutes before the scheduled procedure to obtain the permit for the first scheduled patient.
4. Discharge from the recovery area: With our conscious sedation policy currently in place, it is necessary for a physician to assess the patient prior to discharge from GI Procedures and sign a discharge order.
5. You are responsible for placing any pathology bottles in the tub for transport to the surgical pathology labs. Fold the endoscopy report, place path slip (filled out by nurses) on top, punch hole(s) through both, insert rubber band(s), attach labeled pathology bottles, and

place in the tub; then date, indicate number of pathology bottles, and put your initials in the pathology log book.

6. Competence will be documented by your procedure attending. Fellows are expected to meet thresholds for attaining competence as recommended by the ASGE. A computer printout of the procedures you have performed can be obtained from ProVation. Fellows should keep track of all number and type of procedures performed on a bi-annual basis for inclusion in their file for documentation of competency and for Dr. Madanick's review.
7. If a patient does not show up for a procedure, write DNC on the requisition near the date and give the requisition back to the scheduling secretary. The patient is likely to reschedule, for which the requisition will be needed.
8. The endoscopy fellow is supposed to take care of any calls forwarded to him or her pertaining to upcoming scheduled procedures and patients who call with questions regarding issues like pretreatment and contraindications.
9. While on endoscopy rotation, you should be aggressive about having the right of first refusal for all patient cases. Ideally, you should hitch up with an attending and scope with him/her the whole day.
10. Priority for diagnostic/screening cases should go to the more junior fellow on Endo (unless there are two at the same level, then split the cases).
11. Priority for therapeutic cases goes to the more senior fellow.
12. If no dx/screening cases are available, and you are not yet capable of performing the therapeutics, then you should perform the diagnostic exam and turn the scope over to the attending for the complex portions.
13. The surgical resident should be paired with the surgeon when he is there. When he is not there, cases should go to fellows first, then the resident. In the absence of a GI attending and if the surgeon is present and has no resident, the fellow can work with the surgeon.

You are responsible for communication in writing to the referring physician for every case you do. These letters should be prepared from ProVation within 14 days and mailed within 30 days after the procedure and contain the reason(s) for the procedure, findings during examination, pathologic results, and treatment recommendations, if any.

The medical records staff and GI procedures clerical staff no longer pull paper charts daily for use in GI Procedures in that this has involved much work to produce little useful information. The CIS and the requisition forms generally provide sufficient information. However, if you do need to review a patient chart, it usually arrives 15 minutes following a stat request. If you know in advance of a procedure for which you will want the chart, the clerical staff can make a request for the chart to be delivered. If you need to compare new images to old ones, you can look at the old ones once the chart arrives.

Support staff can schedule appointments per faxed requisitions or per phone request. If a physician's office calls to schedule an appointment while the patient is in their office, the secretaries will schedule it so that physician's office can relay the appointment time. If the appointment is scheduled by phone request, the secretaries will reinforce the necessity to fax the required referral

form. From the recall list of all patients scheduled on a given day, the secretaries will confirm that all request forms were faxed. If a request is not received, secretaries will notify the referring physician's office, letting them know that, in order to keep an appointment time, a request form must be submitted. Secretaries will keep a list of referrals not received; if one does not arrive three days prior to the procedure, the endoscopy fellow will call the referring physician's office to follow up. Secretaries will place all faxed referrals in a box daily so that the endoscopy fellow can review them at the end of the day. This fellow will initial that s/he has reviewed them. The following day, the secretaries will file in a correct appointment day slot. These referrals will then be placed with the patient's paperwork upon patient check-in. If a patient calls to reschedule an appointment, secretaries should pull the referral request and place it in an appropriate slot for a rescheduled date.

It is the responsibility of the endoscopy fellow to review requisitions on patients who are coming in for procedures prior to their arrival. This has traditionally been done the day before, at which time it is often too late to work on pertinent issues such as coagulation and to assess whether the correct procedure is being performed. We have therefore switched to a system where the requisition will be reviewed when the requisition is sent in (usually the day it is scheduled). There is a box in the GI Procedures secretarial area for your review of requisitions. Ideally, a review should be done every 1-2 days. Once you review the requisition, you should address any issues such as Coumadin and rationale for the procedure, place comments on the form, sign it, and return it to the secretaries. On average, this amounts to 5-7 forms per day, and this can be done at any time during the day. In the past, review of endoscopy requisitions has gotten way behind. In fact, Dr. Isaacs went through 100 of them for approval. It is important to keep up with routine review of these forms because they can fall rapidly behind. The endoscopy fellow may want to recruit the assistance of all clinical fellows as a whole to do this per assigning fellows or through their voluntary involvement on a rotational basis. Requisitions should be submitted for all procedures, even 'to do' ones.

Scheduling Guidelines

Procedure scheduling length guidelines: {Earliest start times for any case is 8 AM, except for study patients assigned to the fluoro room at 7:30 AM and Capsule Endoscopies (see below for specifics). Earliest start times for any case on Thursday is 9 AM.}

Colonoscopy: 45 min – Last scheduled Colonoscopy is 3:30 PM

Double Procedures: 60 min – Last scheduled double procedure is 3:00 PM

EGD: 30 min – Last scheduled EGD is 3:00 PM

Enteroscopy: 30 min – Last scheduled Enteroscopy is 3:00 PM

ERCP: 90 min – Last scheduled ERCP is 3:00 PM

Flex Sig: 30 min - Last scheduled Flex Sig is 3:30 PM

Linear EUS/FNA: 90 min – Last scheduled Linear EUS is 2:30 PM

Radial EUS: 45 min – Last scheduled Radial EUS is 3:00 PM

If a physician anticipates a difficult case requiring more time, s/he should notify the scheduling secretary and request appropriate time. A scheduler is available during regular business hours (Monday – Friday, 8 AM until 5 PM).

Only cases with a referral are scheduled, except for verbal requests from GI attendings or their administrative assistants. Otherwise, referrals must be received from everyone in order to schedule a procedure. Referrals may be received by fax or hand delivery. A screening colonoscopy may be scheduled for a procedure as an open access by the patient. If the case is a follow-up case, no posting slip is required. An appointed person has been assigned to call patients at least five (5) days in

advance of their scheduled procedure to confirm appointments and to verify that the patients have received prep instructions. The scheduling staff maintains a voicemail log, and any problems or issues need to be reported to the nurse manager, immediately: 6-5563 (GI Lab), 6-0244 (Office), or 347-0842 (Pager).

Physicians will be scheduled for AM and PM: AM 8am-12pm (9am start time on Thursdays) and PM 12pm-4pm (or when day is complete). These physicians are *required* to be in the GI Procedures Unit during that entire time. Leaving for a quick clinic visit, lecture, rounds, appointment, etc. is not permitted unless you have arranged for another physician not simultaneously scheduled to be in the unit to cover for you. A physician should not leave until this coverage arrives in the unit. If a physician is unable to make an entire block assignment at any given time, it is their responsibility to arrange coverage. Fern Jeremiah should be contacted immediately with any schedule changes (phone 3-0758 or email fern_jeremiah@med.unc.edu) so that she may update the web page (amion.com). Fern will in turn contact the nurse manager so she can notify the schedulers.

Room Assignments:

Room 1: generic assignment/EUS (**exceptions:** Tuesday PM – room is reserved for Dr. Gangarosa’s “to do” cases only; Friday – room is reserved for Dr. Grimm’s to do” cases only)

Room 2: generic assignment

Room 3: generic assignment

Fluoro Room (Room 7): Please schedule all ERCP’s in this room. This room is intended for the biliary MD on their assigned days in AMION. (We also use this room internally for overflow.)

As of 2/13/07, we have an additional fluoroscopy room, as purchased for us several years ago as part of an initiative to increase the capacity of the Center for Pancreaticobiliary Diseases. This C-arm fluoro unit has since been housed and used in the operating room, awaiting completion of our second fluoro suite. It is operated by radiology techs whenever the surgeons request it. When we have used it in the past, we have also called upon a radiology tech to help work the equipment. The radiology department asks that we get training in using this equipment, so that we do not need to rely on their techs for support. This is somewhat ironic, since the radiologists can submit their bills for reading our films, without even having to provide technical support for us; however, there are advantages to our getting trained and becoming self-sufficient in the fluoro suite.

The C-arm can and should be used for all sorts of non-ERCP indications, especially tube placements of any kind. Any case involving placement of a mano catheter, colon decompression, or any feeding tube should be placed in this new fluoro room. We can do a routine tube study after any PEG placement by injecting contrast through the tube under fluoroscopic observation. Fluoro is hardly used nowadays for performing difficult colonoscopies, but using it provides an excellent education on looping of the scope and ways to avoid it. There is no reason, then, not to put a difficult colon case in that room, and no reason, then, not to use that space to confirm all mano catheter placements with a quick fluoro check. Our additional fluoro suite allows us to provide an excellent way to see what happens during a Maloney dilatation and to see if a pancreatic stent remains in place.

Please make as much use of the C-arm as possible so that it does not migrate back to the OR. We need to communicate the expectation that this equipment will remain permanently in GI procedures and that we will always want and need to have it available. To this end, please ask the charge nurse to place all feeding tube and colon decompression cases in the new room.

MD Assignments:

Physicians are assigned as follows: There is a biliary attending and two additional attendings assigned to the unit each day. Please check the RYOUON calendar when a request is made for a “to do” to see when that particular MD is assigned to the unit. Also please note that there is an attending assigned to capsule endoscopy every day but Thursday. There are no outpatient capsules scheduled on Thursday’s. Please have the fellows or attendings check with the charge nurse for scheduling inpatient capsules on Thursday’s.

EUS Guidelines:

The following persons can only schedule EUS: any attending MD or one of the GI Fellows. Future scheduled EUS records may arrive at the scheduling area and are to be placed in the designated file cabinet. Please make a note in IPATH in the ‘notes’ section that “records are included.” The file will be pulled the morning of the scheduled EUS case from the file cabinet so that the file will be ready for the MD prior to the case. The schedulers can pull these files first thing in the morning and give them to the charge nurse.

Capsule Endoscopy Guidelines:

The following persons can only schedule Capsule Endoscopies: Dr. Doug Morgan, Dr. Kim Isaacs, or one of the GI Fellows under the direction of Dr. Morgan or Dr. Isaacs. Future scheduled capsule endoscopy records may arrive at the scheduling area and are to be placed in the designated file cabinet. Please make a note in IPATH in the ‘notes’ section that “records are included.” The file will be pulled the morning of the scheduled capsule from the file cabinet by the front desk schedulers so that the file will be ready for the MD prior to the case. Please send the file to the charge nurse desk first thing in the morning. Capsules must be scheduled no earlier than 7:15 AM and no later than 8:00 AM. No more than two (2) capsules per day may be scheduled. Nia Riggsbee is to send an email to Dr. Morgan, Dr. Isaacs and the fellows each Friday at 3 PM in regard to upcoming schedule for the following week’s capsule endoscopies with the patient’s name and scheduled date and time. There is also a capsule endoscopy-scheduling notebook located at the front desk, which the schedulers use to post these cases. Please allow at least seven (7) business days when scheduling these procedures for insurance purposes.

Manometry Guidelines:

There are multiple procedures performed in the Manometry Unit, including: Urea Breath Test (also referred to as a C13 test for H. pylori); Hydrogen Breath Test (for Bacterial Overgrowth and Lactose or Sucrose Intolerance); Anorectal Manometry; Esophageal Manometry; and adult-pediatric pH probe studies. These cases are scheduled in the “red notebook” when a referral is received. Once the case has been posted in the “red notebook,” the appointment is then placed into IPATH, and an appointment slip is generated via the dot matrix printer. All inpatients are scheduled directly through Shelia Crawford, thus skipping this process.

Patient Check-In Process:

All outpatients at the Memorial Hospital location must go to the Registration Hub first to check in for payment and insurance purposes. The hub is located on the first floor of Memorial Hospital, next to Precare. All patients need to arrive one hour prior to their scheduled appointment in order to go through this check-in process.

Overbooking:

We do not allow overbooking at this time.

EUS cases are scheduled in Room 1 (to prevent double-booking and back-to-back booking with scope use). If an EUS “to do” is scheduled in room 1, that doctor cannot schedule another “to do” within the first hour of that case.

ERCP cases are scheduled in the fluoro room (room 7) only. If an ERCP “to do” is scheduled in the fluoro room, that doctor cannot schedule another “to do” within the first hour of that case.

Procedures in prep-recovery are limited to one (1) case per day (e.g., liver biopsy, paracentesis).

M & M Issues in the Procedures Unit

A – DOCUMENTATION: For anyone involved in performing a procedure, it is extremely important to document any patient complaints that develop after a procedure, for quality assurance control as well as malpractice reasons. Patients who experience a complication from endoscopy commonly allege that they had symptoms of the complication that were initially ignored or not properly attended to. The recovery room nurse should alert the appropriate medical staff regarding all complaints of post-procedural abdominal pain or other concerning symptoms. All physician evaluations need to be documented as an addendum to the procedure report or as an interim note on CIS. The same applies to any phone calls from or correspondence with patients following a procedure.

B – PROPER DEVICES: Per JCAHO, nurses are required to perform a ‘time out’ to identify the patient and the procedure prior to the scheduled exam. We have instituted a similar policy regarding devices to be used during a procedure, in that the nurse should verbally identify the contents of a packaged endoscopic device and confirm that it is the correct device before that package is opened. This policy should help reduce losses from contaminating incorrectly selected accessories. Physicians especially need to be sure that a device is of the proper diameter and length before it is opened. Problems often occur if a device intended for the upper GI tract (e.g., esophageal balloon) is used as a colonoscope or an enteroscope. Some devices only fit in a large channel therapeutic upper scope, such as a jumbo Roth net. If you are uncertain about whether a device will fit through the scope you are using, please ask for assistance rather than opening a device that may end up having to be discarded unused. You may need to remind the nurses to be more specific about the exact contents of a package, e.g., a metal biliary stent needs not only the length and diameter verified, but also whether or not it is a coated stent. It is easy for a nurse to confuse a crescent snare with a duck bill snare. The only way to avoid this is to verbally verify the contents before every package is opened.

C – BLOOD PRODUCTS: There have been instances in which a patient arrived in procedures and was placed in a procedure room, only to have the procedure postponed because of a need for blood products. Examples include a case involving a type and screen request for possible cystenterostomy and a FFP request for possible sphincterotomy in a cirrhotic patient. In both cases, the procedure was begun, pending completion of the order at the blood bank. Such cases cannot begin until actual blood products have become available. It is difficult to predict the need for blood products, however. There is a low threshold for ordering type and screen in cystgastrostomy patients, and there is no exact cutoff for an acceptable INR value for a cirrhotic requiring sphincterotomy, but clearly a patient with this profile is at increased risk for post-sphincterotomy bleeding.

Conferences

Each year during the second weekend of March, the Medical University of South Carolina (MUSC) Digestive Disease Center presents a workshop on advanced endoscopic procedures, aimed at fellows in their final stages of training. This program consists of live demonstrations, lectures and discussions. MUSC requests that one senior fellow attend per fellowship program. Through an educational grant from AstraZeneca, the fellow does not have to pay for local accommodation, daytime meals or the course dinner. However, s/he does have to pay for travel expenses. For more information about this workshop, please contact Rita Oden, 843-792-6865, odenr@musc.edu. MUSC's web site is <http://www.musc.edu>, with specific sites <http://www.ddc.musc.edu> and <http://www.gastroHep.com>.

The University of Utah/Brigham and Women's Hospital has an annual therapeutic endoscopy program for fellows at the Yarrow Resort Hotel and Conference Center in Park City, Utah. The day includes didactic lectures on the latest therapeutic endoscopy techniques. Hands-on training utilizes ex-vivo models and state-of-the-art endoscopes to familiarize the trainee with the most up-to-date therapeutic devices and techniques. Advanced therapeutic and third-year fellows are preferred; however, this opportunity is open to all GI fellows, regardless of year of training. Fellows are able to attend the annual Utah/Brigham and Women's Therapeutic Endoscopy Conference from March 18 – 20, 2009, with the fellows' course being held on March 18. This course is designated as an ASGE interim post-graduate course. A scholarship of \$1000 is provided to the fellow to help defray the cost of travel, lodging and meals for the fellows' course and the therapeutic endoscopy course. Registration fees are waived for participating fellows for both the fellows' course and the following regular course. Because of limited funding, only 30 fellows across the country are offered a scholarship to participate in this program. Registration is on a first-come, first-served basis. If you have any questions about this opportunity, please contact Beth Quinney at 801-581-7803 (fax 801-581-7476). For fellows, please visit "GI Fellows Day" under "Conference Center" at www.int.med.utah.edu for detailed information and registration. The fellows' course focuses on bleeding, stenoses and fistulae of the GI tract, pancreaticobiliary disease, screening and surveillance, and new trends in endoscopy. Didactics include trans-nasal endoscopy, enteral access, double-balloon enteroscopy, mucosal resection, clips and loops, luminal stents, and metal stents. Hands-on stations include double-balloon enteroscopy, enteral access – trans-nasal endoscopy, luminal stents and clips, mucosal resection – argon plasma coagulation, ablation by APC, and ERCP maneuvers, using simulated pig models.

The University of California at Irvine has had its Sixth Annual Symposium on Interventional Endoscopy on September 26-27, 2009 at the Doubletree Hotel in Orange, CA. This is a two-day intensive course where world-class endoscopists are invited to discuss and demonstrate cutting-edge modalities such as EUS, ERCP, PDT, GERD therapy and transgastric surgery. Through state-of-the-art audiovisual integration from the H. H. Chao Comprehensive Digestive Disease Center to the Doubletree Hotel, the audience is exposed to a myriad of live case demonstrations by experts in the field. In addition, live feed from the experimental endoscopy unit allows the audience to see and experience new and emerging technologies in animal models. There is ample opportunity for audience interaction with the faculty during the cases and panel discussions.

All fellows are encouraged to attend at **no charge** – registration fees have been sponsored through educational grants from industry sponsors. Please contact the course coordinator, Grace Chen, at 714-456-3721 or email her at gracec@uci.edu for additional information or questions. Mailing and other information includes: H. H. Chao Comprehensive Digestive Disease Center, 101 The City Drive, Building 22C, Room 106, Orange, CA 92868, fax 714-456-5820.

One senior or advanced fellow can be nominated to attend the Annual GI Fellows' Course in Advanced Endoscopy held at the University Hospitals Case Medical Center, this year on August 13-14, 2009. The special course is designed primary for advanced GI fellows in their fourth tier who are just starting their extensive training in advanced procedures such as ERCP, EUS, and double balloon enteroscopy. Its format combines didactic sessions with "hands-on" instruction in ex-plant and live porcine models.

This by-invitation-only course is free of charge to institutions. Each institution must provide transportation for the fellow to travel to and from Cleveland. Expenses for the hotel stay, daily breakfast, lunch and the final course dinner are covered. The fellow's stay is arranged at the Wyndham Hotel, located in the Cleveland Theatre District. Each nominated fellow is assigned a roommate @ two fellows per hotel room. If a fellow does not wish to share a room with another fellow, s/he is responsible for the cost of the hotel room. For more information, contact Cynthia S. Shega, program administrator, at cynthia.shega@uhhospitals.org, phone 216-844-8394, fax 216-844-8201. The mailing address includes: Case School of Medicine, 11100 Euclid Avenue, Lakeside 5047, Cleveland, OH 44106-5047.

Last year, Mayo Clinic held its 'Advances in Endoscopy' CME course on July 31-August 1 at Disney's Yacht & Beach Club Resort in Lake Buena Vista, FL. Highlights of the course include

- Get the latest updates on new endoscopic imaging systems;
- See and learn through a hands-on lab advanced techniques;
- Learn ERCP and EUS techniques using tools in a simulation center;
- Debate practical, daily challenges facing the endoscopist

This two-day CME course features lectures with national and international experts, live endoscopies and a hands-on workshop to practice skills to improve performance of advanced therapeutic endoscopic procedures such as advanced imaging methods, endoscopic mucosal resection, and double balloon enteroscopy. By the end of the course, attendees should be able to evaluate different approaches to the detection and endoscopic therapy of dysplasia in Barrett's esophagus and ulcerative colitis; set up programs for quality improvement and monitoring; and describe future trends in endoscopic practice and technology. A video learning center featuring the most current ASGE DVDs is also open to all participants.

Course learning objectives include

- Improved performance of advanced therapeutic endoscopic procedures such as advanced imaging methods, endoscopic mucosal resection and double balloon enteroscopy;
- Evaluation of different approaches to the detection and endoscopic therapy of dysplasia in Barrett's esophagus and ulcerative colitis;
- Establishment of programs for quality improvement and monitoring in endoscopy;
- Description of future trends in endoscopic practice and technology.

Attendance at this Mayo course does not indicate or guarantee competence or proficiency in the performance of any procedures that are discussed or taught in this course. The overall focus of this course is the improvement of patient care. Thus, a nurses session is included as well, such as ensuring quality care in the endoscopy unit and nursing education in the GI lab, in addition to a

portion of the conference devoted to the management of an efficient endoscopy center. Program information includes: Mayo School of CME, 4500 San Pueblo Road, Jacksonville, FL 32224; phone 800-462-9633 (904-953-7146), fax 904-953-2954; email cme-jax@mayo.edu. To register online, visit www.mayo.edu/cme.

GI CONSULT ROTATION

Goals

1. Develop confidence in handling routine inpatient gastroenterology consultations.
2. Learn to appropriately triage inpatient consultations and requests for transfer from outside physicians.
3. Develop an effective strategy and knowledge base to handle after-hour calls from patients.
4. Read assigned topics regarding management of inpatient issues to include:
 - a. GI bleeding
 - b. Acute pancreatitis
 - c. Fulminate colitis
 - d. Small bowel obstruction
 - e. Volvulus and colonic pseudo-obstruction
 - f. Chronic diarrhea
 - g. Abdominal pain
5. Learn how to write an effective consult note and communicate the pertinent information to the requesting teams.

GI CONSULT FELLOW RESPONSIBILITIES

1. See inpatient consultations including those seen by the GI resident and students on the team. You are responsible for all non-hepatology consultations called in between 8:00 AM and 5:00 PM on weekdays. You will pick up any non-hepatology GI consults done by the on-call fellow at night or on weekends. As of 7/1/04, because of the dissolution of our Med A service into the General Medicine U and W services and a significant increase in GI consults, fellows have the option of blocking continuity clinics during GI consult service.
2. Consultation notes must be complete and include comprehensive history, social history, family history, review of symptoms, comprehensive physical examination and assessment/recommendations. The attending physician responsible for calling the consult must be documented on the consultation note. In addition, it must be documented on the consultation note that you communicated to the requesting team the impression and recommendations. This is required to bill for a consultation. These are the same elements that will be required on your consultation notes when you go into practice. The consult attending must provide appropriate documentation. The expectation is to have a note in the chart on the same day, or at most within 24 hours of the consult. Consult notes no longer need to be forwarded to Tina Blanton, our coder, who is able to access them from her work activity list on WebCIS (8/2/10).
3. Carolina Consultation calls are handled by the GI consult attending.
4. Outpatient consultations are triaged by the consult attending. The inpatient consult team may see the patient. The patient may be triaged to the biliary fellow, the manometry fellow, the endoscopy fellow, or the backup fellow depending on the problem. If the outpatient

consultation is not urgent, the patient can be triaged to the General GI Clinic if space is available.

5. Any new GI patient you see in the hospital requiring outpatient follow up will become your responsibility in the outpatient clinic and should be scheduled as a follow-up appointment (not as a new patient appointment) in your regular clinic. It would be helpful if the consult fellow could email our Appointment Center (csgi2@unch.unc.edu) with the name, medical record number and appropriate physician (in most cases you as the fellow) of those patients we are to follow up in clinic so that when the ward clerk or intern calls this can be taken care of more efficiently. If you name a physician other than yourself, please cc that individual as well.
6. For inpatients requiring endoscopy, the consult fellow should submit a list the night before to the charge nurse so that it is available for her first thing in the AM to better streamline the inpatient procedure process and to avoid late add-ons, which can disrupt the flow of throughput in the unit. Please do this on a daily basis. To this end:
 - Provide the charge nurse of certain critical values that patients have, so there are no unexpected complications such as thrombocytopenia or coagulopathy.
 - It is expected that the charge nurse will maintain open communication with the fellows regarding patient concerns.
7. Be specific about any special diagnostic or therapeutic maneuvers that should be undertaken when a patient goes to endoscopy, thus:
 - When you are scheduling the case, notify the charge nurse about any special maneuver;
 - Write a clear note on the wipeboard next to the patient's procedure;
 - Ask the charge nurse to remind the nurse and attending for the case about any special maneuver;
 - If possible, try to find out which attending will be performing the case and remind him/her yourself as well.
8. If any problems arise, please let the consult attending know immediately so that the problem can be addressed.
9. Travel endoscopy cases are expected to be covered by the consult fellow and the consult attending. All other cases are covered by the attendings in the Procedures Unit. If the Procedures Unit is overbooked, the consult team may be asked to help out with the procedure.
10. If you are on the consult service, you should not scope unless you scope one of the consult patients. Otherwise, if you are on consult service and not rounding, you should be reading about your patients.
11. Consult fellows are expected to orient, guide and instruct 4th-year medical students and residents rotating through our consult service.
12. Before you leave for the day sign out to the on-call fellow.

NOTE A: Fellows on the consult service should be attentive to the presence of an implanted defibrillator in any patient who will be having a procedure, as the charge nurse needs advanced

warning to contact cardiology to turn off the device, particularly if electrocautery is to be used. A bipolar probe is NOT a cause for concern, but polypectomy or argon plasma coagulation (or any time there is a grounding pad on the patient) potentially could disarm and set off a defibrillator.

NOTE B: Our colleagues in the bone marrow transplant unit are requesting that we routinely obtain colonic biopsies for CMV by PCR, as well as biopsies for GVHD in the evaluation of post-transplant diarrhea, regardless of whether the mucosa is normal in appearance or not. There apparently have been several issues recently involving miscommunication of similar requests. In order to be certain that all of the correct procedures are performed on GI consult cases, we should adhere to the following procedures and policies:

- The consult fellow should indicate in the written information provided to the charge nurse if any special maneuvers are requested.

The charge nurse has been asked to create a column on the board specifically for consult cases, where special requests can be written in, ideally with a unique color so they stand out. We have recommended the institution of a standard policy of asking the procedure room nurse to page the GI or liver consult fellow at the start of *every* consult procedure: this should facilitate communication between the consult team and those performing the procedure and also allow the consult team to see the endoscopic findings, should they so desire.

The consult fellow need not return every such page if the outgoing is drafted correctly, e.g., “EGD starting in room 3 now on Mr. Smith – call if any special requests”. If the procedure attending deems that the special request is inappropriate, they should discuss this with the consult team before terminating the procedure. If all of the faculty can remember to ask the procedure nurse to send a courtesy page to the consult fellow, this practice should soon become habitual.

POLICY ON “BLOCKING” OF CONSULTS

When the luminal or hepatology fellow is called for a consultation, we do not endorse the actions of trying to “block” the consult, whether the consult is for a positive fecal occult blood test or chronic abdominal pain on a patient we have seen a number of times. If a colleague on another service asks for our opinion or advice, it is our duty as physicians who run a consultative service to provide this, even if you think it is unreasonable, unwarranted, or unnecessary.

If you do not have the time to do a consultation that is not urgent, please let the referring physician know the situation. Remember that there is always someone who can and should see the patient if you cannot. And never, under ANY circumstance, make the referring physician feel that he or she was stupid for calling you. That is a sure way to alienate the referring physicians and prompt a comment to your attendings or other important people.

FACULTY POLICY:

- Please be vigilant about the time spent on work rounds with the fellows. Fellows need to regularly have a 10-hour break between ‘shifts’ in the hospital or clinics, which means that they need to be out of the hospital by 9:30 p.m. or 10:00 p.m. at the latest if they are to arrive by 7:30 a.m. or 8:00 a.m. to begin work the next day.
- When the service is very busy, please make sure that rounds are completed with adequate time for the fellows to complete their duties within this time frame. (They do not have to

stay late to dictate or write their notes. This can be done from home, and these hours do not count toward their 'in-hospital' time.)

- This does not necessarily pertain to the occasional on-call fellow who needs to come in to do endoscopy or evaluate a critical patient.

CO-FELLOW POLICY:

Please assist your colleagues when you can. If we have service that spikes, and you are on an opposite service (endoscopy, motility, nutrition, research) and can see 1-2 new consults on their behalf, please volunteer to do so, as this greatly helps out, and provides additional exposure to this important realm of GI practice. *If the consult fellow feels overwhelmed or tired and anticipates doing a consecutive in-house stretch beyond 24 hours, that fellow must notify the program director immediately so that arrangements can be made to ensure that we remain within compliance of duty hour policy AND promote resident (in addition to patient) well being and safety.*

GI fellow's guide to using electronic notes on the consult services

In order to practice:

- open WebCIS and bring up a practice patient, last name: "Test", MRN # 1165466-2

Writing a new inpatient consult note:

To get started:

- open WebCIS and select your patient
- go to the "create notes" tab
- select "inpatient consult notes"
- push the "new" button
- the template for a new note will open, as a default, to the "service" tab
 - fill in the admit date; we are the consulting service (MEDICINE::DIGESTIVE DISEASES); select the requesting service; fill in the attending physician - if there is one already there, confirm that it is the correct person
 - push save; as a rule, you should save your work frequently
- proceed through the different tabs, entering the data; on some pages (RoS, PE) there are radio buttons that will add default text

Tips for initial consult notes:

- it is useful to have a second instance of WebCIS open to the same patient, so you can copy and paste text and results quickly - just be sure not to confuse the two...
- you can stop work on your note at any time, save it, log out of WebCIS, and come back to your note later; to do this:
 - save your work
 - push the cancel button - this will take you back to a default screen where you will see an open red folder to the left of a description of the note you have started - this is the partially completed note
 - to reopen this note, click on the red file icon and you are able to resume your work
 - to delete this note, click on the delete icon
- when you get to the "assessment and recommendation" tab, you can copy and paste from the template for common consultation recommendations, if you so desire
- it is a good idea to print out the completed note for reference on rounds, and to use for billing purposes if the system goes down or the note gets lost (which has happened on two occasions so far...)

When the note is finished, you must route it to the proper attending to cosign it, and also route it to GI billing:

- push the "sign & route" button; you will be asked if you really want to sign this - remember once you sign the note, it is published to the reports section of WebCIS and is accessible by all - click "OK" to proceed
- this brings you to the routing page
 - first enter your attending's last name, push the "search" button, and then push the "co-signature" button - this will route your signed note to the attending's unsigned report list on WebCIS
 - now enter Tina Blanton's last name, push the "search" button, and then push the "notification" button - this will send a copy to Tina for billing purposes, once the attending has signed their copy of the note
 - you may also send notifications to anyone involved with the case (i.e., interns, team attending, etc...) if so desired
 - now your attending can find the preliminary note in their activity list
 - select the proper note to open it
 - if they wish to edit anything you have written, they can click on the appropriate headings and make changes
 - when finished, they need to select the "teaching physician note" section and select the appropriate value from the drop down menu (usually "new patient, resident performs service") - this will automatically write their attestation for them
 - this is another opportunity for the attending to add extra comments, if so desired (but extra comments are not needed for billing purposes)
 - finally, they sign and finalize the note

Be sure to let the consulting team know that the note is in WebCIS, either with a text page or by writing a quick line in the chart.

Writing a new daily (follow-up) progress note

To get started:

- open WebCIS and select your patient
- go to the "create notes" tab-
- select "progress notes"
- push the "new" button
- the template for a new note will open, as a default, to the "service" tab
 - fill in the admit date if needed (often, this will be automatically filled in)
 - push save - again, save your work frequently
 - in the "initial history" tab, I recommend writing: GI (LUMINAL) CONSULT FOLLOW-UP NOTE or HEPATOLOGY CONSULT FOLLOW-UP NOTE as appropriate; this will give each note a header and identify the service, which is not an available function elsewhere. Additionally, the initial history (ie 42 yo W a/w melena and found to have a bleeding DU) is often the first line of the assessment anyway, and does not have to be repeated.
 - fill in data in the other tabs as needed
 - sign and route the notes in the same manner as the initial consult note

Tips for follow-up progress notes

- to save time, only enter key labs in the "diagnostic test" section; otherwise you can type "see WebCIS for labs"
- you can start, stop, and resume these notes in the same manner as the initial consult notes

- once you have entered the data for the initial follow-up progress note that you have written and have signed that note, the following day all of the information that you have entered should be carried forward to the new note, greatly decreasing the amount of work you have to do to add data to the note
- discuss with the attending how they would like to plan rounds - options include signing each note after seeing each patient or seeing all patients and then signing the notes afterward
- it may be useful to print out a copy of your daily note to refer to on rounds

Please be attentive in making sure you select specific tabs within WebCIS. These tabs allow you to add required documentation for higher levels of billing (99254 and 99255). Our coder has seen the PFSH left off of consults as well as the ROS tab. In reviewing your documentation after entering it in WebCIS, please remember to make sure that these areas have been documented before sending them to the attending.

Also, now that so much of what used to be written is now typed/keyed in and care providers are sitting for longer periods of time and entering in information, work areas may not be ideally ergonomic for this purpose, such as the fellows' work room. If this is the case, please notify the coordinator, who will be glad to order wrist pads to help better this situation.

NUTRITIONAL EDUCATION

Fellows are required, during their second clinical year, to complete a self-instructional video tutorial program. These include interactive CDs from the Nutrition in Medicine (NIM) Group here at UNC, which cover the following topics: diabetes and weight management; diet, obesity and cardiovascular disease; nutritional anemia; nutrition and cancer, and nutrition and metabolic stress. The fellow can review these independently and discuss any questions with the attending. The program is now web-based, and the web address is <http://www.med.unc.edu/nutr/nim/>. After registering on-line, the fellow receives a password by email that s/he can use to log in to the module training site. Once at the site, the password for all individual courses is 'melon'. Our fellows might find the modules somewhat basic since they are designed primarily for undergraduate and graduate college students. The NIM Group is currently applying for funds to do a similar series for medical students, fellows and practicing MDs. Hopefully, the fellow can benefit to some extent from these modules. The four courses that we recommend – which should be of use to our fellows – include nutrition support, metabolic stress and starvation, obesity, and cancer nutrition. Dr. Martin Kohlmeier is the Director of our NIM Group. Once the fellow begins the tutorial program, s/he should email Dr. Kohlmeier at mkohlmeier@unc.edu so that he can send information specific to the various modules.

In view of the increasing prevalence of obesity, and the lack of standardization of requirements and guidance in the GI core curriculum, the AGA Institute has developed an online Nutrition Toolkit Series to provide trainees with obesity and nutrition disease specific education. Each module includes slides with corresponding audio delivered by subject experts, along with pre- and post-test questions. Fellows can access the modules on their own time and, at the completion of the module, receive a score report, which they can email directly to the fellowship program director for review. Two online modules are currently available, **Obesity for the Gastroenterologist** and **Nutrition in the Patient with Liver Disease**, with other topics in development. The AGA strongly encourages GI fellowship programs to incorporate these modules into their existing curricula as an effective means of educating fellows on the role of obesity in GI and liver disease, with appropriate management and treatment plans. Modules are available only to AGA members and can be accessed at www.gilearn.org/obesity.

From a more practical standpoint, we encourage our fellows, while on the nutrition rotation, to round with our PEN team. These individuals are all quite experienced and competent. Although having a fellow round with them takes some extra time on their part, they have always been willing to give that time to our fellows as long as the fellow is willing to put forth the effort as an active participant. Interested fellows should contact Beverly Holcombe, RN, at 6-5991 or BHolcomb@unch.unc.edu. Below appears a description of our PEN Service and expectations set for our fellows who elect to work with this team.

In August of this year, Dr. David Frantz had the opportunity to participate in Nestle Foundation's nutrition fellowship program, a one-month rotation comprising of two weeks in Portland, Oregon, under the direction of Dr. Robert Martindale, and two weeks in Louisville, Kentucky, under the direction of Dr. Stephen McClave. This intensive program has been held for many years and is recognized as an outstanding educational opportunity for those specializing in the field of nutrition. Dr. Frantz was chosen among five other fellows nationwide and was provided with a rigorous state-of-the-art curriculum covering virtually all aspects and areas of nutrition, which he can now share with members of our team. This program helps prepare the budding GI nutrition specialist to network with mentors and future collaborators for research projects towards advance career planning and eventual placement. The fellowship program extends beyond the actual rotation itself: David is expected to complete a research project in communication with, and with the assistance of, an assigned mentor, and he is expected to attend and possibly present research findings at the ASPEN and ESPEN (national and international nutrition conferences), respectively. We are pleased that this educational mechanism sponsored by Centers of Excellence is in place so that any of our fellows with an interest in nutrition may be able to benefit from it.

GOALS OF THE NUTRITION ROTATION

Nutrition support. Trainees should understand how to use oral, enteral, and parenteral feeding techniques to prevent or correct specific nutrient deficiencies and to provide appropriate protein, energy, fluid, vitamin, and mineral intake in patients who are unable to maintain an adequate oral intake of nutrients because of short-bowel syndrome, nausea and vomiting, inability to swallow, severe illness, psychiatric illness, or altered mentation. These approaches require an understanding of the following:

1. Nutrient requirements
2. Indications for and composition of diets modified in nutrients or consistency
3. The physiological principles of oral rehydration therapy and appropriate use of oral rehydration solutions
4. The use of enteral tube feeding, including indications, feeding tube options, tube placement techniques, composition and proper selection of liquid formulations, monitoring tube feeding, and complications
5. The use of parenteral (central and peripheral) nutrition, including indications, catheter options, catheter placement and care techniques, composition and proper selection of parenteral formulations, monitoring techniques, and complications
6. Drug-nutrient interactions

INPATIENTS

The PEN Service is different from most Consult Services. First, it is not a consult service. Second, it consists not only of physicians but also a pharmacist, nurse, dietitian, and often a Doctor of Pharmacy student.

The dietitian, nurse, and pharmacist are experienced members of the PEN Service and are knowledgeable about nutrition support. These individuals -- together with the attending physician -- are valuable resources for you in learning what you need to know about nutrition support. The names of the PEN Service members are listed at the end of this section.

The Service reviews and writes notes for all adult patients receiving peripheral or central TPN. Someone from the team or the entire team sees each patient at least six days each week for as long as the patient is receiving TPN. In addition to the initial note, notes are written in the chart for patient care and/or educational purposes every 1-3 days. On request, the service provides nutrition consultation for adult patients not on TPN.

HOME ENTERAL PATIENTS

The Social Work/Continuity of Care Department coordinates home enteral nutrition.

Home I.V. Nutrition

The Nutrition Support Nurse coordinates the management of adult patients who are discharged on home TPN. You may be involved in discharging patients on home TPN.

DUTIES OF THE GI FELLOW

1. You should work up 2-3 new patients each day and follow them as long as they are on TPN. The team member who is the administrator for the month will notify you of patients started on TPN. You will be expected to take weekend call 1 weekend during the 2 week block. The pharmacist or nurse on service will check the TPN roster in the Pharmacy each weekday and will let you know of patients started on TPN. On weekends, the person on-call should call the Pharmacy I.V. Room (6-2375) and go by the inpatient pharmacy to get a list of all patients on TPN. Patients not already being followed should be seen as new patients.
2. All initial Nutrition notes should be written as Progress Notes. Although the work up and note are identical to a consult note, these are not consults (done automatically and not by request); hence, there is no physician charge.
3. Establish your own routine for daily follow up of your patients on TPN or tube feeding. This should include: 1) review lab results, 2) review progress notes, orders, nurses' notes; 3) examine patient noting, especially any problems with access including feeding tube placement, central catheter placement, or dressing; 4) note the TPN formula or tube feeding product that is infusing and verify the label on the bag against the order; 5) note infusion rate; 6) talk to nurse and house officer, if needed.
4. Patients on tube feeding frequently do not actually get the amount ordered. Therefore, it is important to determine from the nursing notes how much is received. Every 2-4 days, put in your note the volume of tube feeding product actually received and how that compares with the calorie and protein goals.

5. **You must complete the monitoring forms for your patients** on TPN and tube feeding everyday you are on Service. Good nutrition support care involves attention to many details. Although the situation has been gradually improving over the years, residents frequently overlook or misinterpret details that are important for safe and effective nutrition support. Therefore, for good patient care, your education, and education of the resident, it is essential that you pay attention to detail during this rotation. The best way to be sure you are addressing all the important issues is to use the monitoring sheets designed for keeping up with the details. Weights, I &O's, TPN and tube feeding formula, blood chemistries, acid-base balance, etc. are important. Please keep the monitoring records up to date and give them to the nurse or pharmacist when you leave the Service.

PEN SERVICE

Attending:	Telephone Number	Pager
Mark J. Koruda, MD	6-8436	123-3486
Dietician:		
Francine Hsu	3-0563	123-4947
Nurse:		
Linda McElveen, RN	3-6309	347-1122
Pharmacist:		
Beverly Holcombe, Pharm D	6-5991	123-4927

Information pertaining to vitamin and mineral supplements free of gluten can be found at www.freedacom. Fellows may receive requests for dietary information from their patients. The American Dietetic Association, <http://nutritioncaremanual.org/> has some helpful dietary information for GI diseases. Scroll to the bottom of the page and click on 'diseases', then highlight 'GI problems' on the left side of the page. If you are unable to access this site directly (i.e., if it requires a sign on), the UNC Clinical Nutrition Service has a link on their Intranet website to this site: http://intranet.unchealthcare.org/site/w3/nfs/clinical_nutrition.

The 15th International Celiac Disease Symposium was held this year from November 13-15, 2009, in New York City. The American Society for Parenteral and Enteral Nutrition (ASPEN) sponsors their annual 'Clinical Nutrition Week', this year held in Phoenix, AZ, from January 28-31, 2009. To learn more about this meeting, visit www.nutritionweek.org. For more information regarding ASPEN, please write to 8630 Fenton Street, Suite 412, Silver Spring, MD 20910.

This year, on Friday and Saturday, November 27 and 28, 2009, Columbia University College of Physicians & Surgeons in conjunction with The Joan and Sanford I. Weill Medical College of Cornell University and New York-Presbyterian – The University Hospital of Columbia and Cornell, presented their 26th Annual Postgraduate Medicine Course, "Update in Gastroenterology, Hepatology and Nutrition."

The fourth-annual Fellows' Nutrition Course (FNC) is held November 12-15, 2009 at the Crowne Plaza Chicago O'Hare in Rosemont, IL. This exciting program selects 35 second-year GI fellows to attend dedicated lectures about nutrition. The program offers travel to/from Chicago, three nights' hotel accommodation, and all meals. Attendees hear from leading experts in the field who discuss

topics ranging from basic nutrition to nutrition in GI disease to formulas, metabolism and special clinical conditions. Sessions include:

- basic nutrition in energy
- micronutrient requirements
- vitamin and mineral requirements
- complications of nutrition – enteral and parenteral
- obesity management
- nutrition and the elderly

The course offers a unique opportunity for fellows to meet and network with expert faculty and peers who share a similar interest in nutrition. Participants must be nominated to attend. Training directors can nominate only one second-year fellow from their program. Once nominated, fellows are required to submit an application and have their training director sign for endorsement. For more information, please visit www.gastro.org/FNC. In addition, the AGA is sponsoring its Third Annual Fellows' Nutrition Course from November 13 – 16, 2009 in Chicago, IL.

The American Board of Physician Nutrition Specialists (ABPNS), affiliated with the Intersociety Professional Nutrition Education Consortium (IPNEC), offers certification for faculty and fellows who would like to obtain a credential recognizing their expertise in nutrition. The ABPNS offers an annual Certification Examination for Physician Nutrition Specialists. The ABPNS was established by the Intersociety Professional Nutrition Education Consortium to provide a credential that recognizes the expertise of Physician Nutrition Specialists. The ABPNS certificate, which replaces that of the American Board of Nutrition, is intended as the premier comprehensive credential for physicians who wish to identify nutrition as an area of expertise. It is equally accessible to physicians with backgrounds in any of the specialties relevant to clinical nutrition, such as gastroenterology, endocrinology, and critical care medicine. Candidates are required to document at least six months of training in clinical nutrition, either as part of a fellowship in a related subspecialty or as a freestanding nutrition fellowship. For more information on nutrition fellowship training guidelines, see IPNEC's website at www.ipnec.org. Examinations are generally given during the first two weeks of November, with the application deadline being the first of October. An application as well as a detailed Candidate's Handbook are available on the ABPNS website at www.ipnec.org/abpns. IPNEC's headquarters are located at The University of Alabama at Birmingham, 302 Community Health Services Building, 933 19th Street South, Birmingham, AL 35294-2041, phone 205-996-2513, fax 205-934-7438, email shreid@uab.edu. ABPNS's regional headquarters are located at The University of Alabama at Birmingham, 439 Susan Mott Webb Nutrition Sciences Building, 1675 University Blvd., Birmingham, AL 35294-3360. ABPNS's national headquarters are located at 1350 Broadway, 17th Floor, New York, NY 10018, phone 212-356-0660, fax 212-356-0678.

The Celiac Disease Foundation is located at 13251 Ventura Boulevard, Suite 3, Studio City, CA 91604-1838, phone 818-990-2354, fax 818-990-2379. The Celiac Sprue Association of America's (CSA) address for correspondence is PO Box 31700, Omaha, NE 68131-0700, phone 402-558-0600. With Dr. Heizer's – who specializes in malabsorptive disorders including celiac sprue – phased retirement, Dr. Herfarth has kindly agreed to assume this caseload given his interest and expertise in this area.

Nutrition Notes and JN (*Journal of Nutrition*) are published by The American Society for Nutrition (ASN), established in 1928, located at 9650 Rockville Pike, Bethesda, MD 20814-3990, <http://www.nutrition.org>, in addition to *The American Journal of Clinical Nutrition*, www.ajcn.org. The National Home Infusion Association (NHIA) publishes Infusion, www.nhia.org.

GENERAL AND TRANSPLANT HEPATOLOGY SERVICE

Educational Objectives

1. To learn how to function as a subspecialty consultant in hepatology.
2. To gain an understanding of the pathophysiology of liver disease as it applies to the clinical practice of hepatology.
3. To gain a working knowledge of the management of diseases of the liver and the complications of liver disease.
4. To understand the appropriate indications for, use of, and interpretation of liver biopsies.
5. To perform liver biopsies.
6. To gain a working knowledge of the indications for liver transplantation.
7. To have an understanding of the management of immunosuppression in the post-liver transplant patients.
8. To have an understanding of the possible post-transplant complications and their management.

Responsibilities (General and Transplant Hepatology)

1. You will see inpatient general hepatology and liver transplant consultations. If a medical resident or student is on the liver service, you will divide up the consults at your discretion with the assistance of the attending hepatologist. You are responsible for all consultations between 8:00 AM and 5:00 PM, Monday to Friday. You will pick up any liver consults done by the on-call fellow seen at night or on the weekend. You will receive requests for consultation directly from the referring service or from the GI consult fellow if that fellow is called for a consult for a liver problem.
2. You will be expected to perform inpatient transplant and non-transplant biopsies. You will also be expected to perform outpatient liver biopsies, of which there may be up to two a day in the CDU, in which case you are responsible for seeing and discharging the outpatient biopsy patients at the end of the day.
3. You may perform any endoscopic procedures with the liver attending (or suitable substitute) on patients you are following in the hospital if all other work on the consult service is completed, provided that cases are not diminished from endoscopy fellows. The only exception is that of ERCPs, which will be performed by the biliary fellow and attending. You will communicate the need for an ERCP on patients you are following to the biliary fellow in a timely fashion to allow for efficient scheduling of patients. You will continue to follow patients who are sent for an ERCP after the procedure.
4. For inpatients requiring endoscopy, the consult fellow should submit a list the night before to the charge nurse so that it is available for her first thing in the AM to better streamline the inpatient procedure process and to avoid late add-ons, which can disrupt the flow of through-put in the unit. Please do this on a daily basis. To this end:

- Provide the charge nurse of certain critical values that patients have, so there are no unexpected complications such as thrombocytopenia or coagulopathy.
 - It is expected that the charge nurse will maintain open communication with the fellows regarding patient concerns.
5. Be specific about any special diagnostic or therapeutic maneuvers that should be undertaken when a patient goes to endoscopy, thus:
 - When you are scheduling the case, notify the charge nurse about any special maneuver;
 - Write a clear note on the wipeboard next to the patient's procedure;
 - Ask the charge nurse to remind the nurse and attending for the case about any special maneuver;
 - If possible, try to find out which attending will be performing the case and remind him/her yourself as well.
 6. You should pre-round on the liver patients in the morning. Your attending will arrange a time to round with you, generally in the afternoon.
 7. Consult notes are an important method of communicating information for patient management and documenting services provided by the consult. They must be complete and include a comprehensive history (including family and social history and review of systems), physical examination, and assessment/recommendations. The name of the attending requesting the consult must be documented on the consult note in addition to the date and a clear statement for the reason of the consult. You should document that the case was seen and discussed with the liver attending (which must always occur). Please see the 'GI Consult Fellow' section for details on how to prepare consult notes.
 8. Carolina Consult Center calls regarding liver patients will be handled by the liver attending.
 9. Outpatient management is an important part of the overall care of patients with liver disease. In addition, many more transplant assessments are carried out in the clinic setting than in the hospital. The liver fellow is not expected but should try to see patients in the liver attending's clinic and participate in the Wednesday morning Hepatitis Clinic.
 10. A new liver consult patient seen in-house who requires outpatient follow up should be followed by the fellow who saw the patient in-house. Such patients are to be scheduled as follow-up patients. It would be helpful if the consult fellow could email our appointment center with the name, medical record number and appropriate physician (in most cases you as the fellow) of those patients we are to follow up in clinic so that when the ward clerk or intern calls this can be taken care of more efficiently. If you name a physician other than yourself, please cc that individual as well.
 11. You should attempt to look at as many biopsies as possible during the rotation, particularly those biopsies that you perform.
 12. You should assist the GI clinic fellow with the preparation of GI Grand Rounds by offering to present an interesting hepatology case.

13. As part of your didactic training, you are expected to attend a) hepatobiliary transplant conference held the first and third Wednesday of each month from 12:30 p.m. to 1:30 p.m. in the Aventis Conference Room on the first floor of the Cancer Hospital; b) Transplant Selection Committee meeting every Tuesday from 2:00 p.m. to 3:00 p.m. in the Transplant Clinic area on the 4th floor of the Old Clinic Building; c) liver histopathology conference given by the Department of Pathology on the second and fourth Tuesday of each month from 1:00 p.m. to 2:00 p.m. in the Surgical Pathology suite on the third floor (30149) of the Women's Hospital (room 30208).
14. Hepatology fellows are expected to orient, guide and instruct 4th-year medical students and residents rotating through our consult service.
15. Sign out any unstable patients to the on-call fellow before leaving for the day.

FACULTY POLICY:

- Please be vigilant about the time spent on work rounds with the fellows. Fellows need to regularly have a 10-hour break between 'shifts' in the hospital or clinics, which means that they need to be out of the hospital by 9:30 p.m. or 10:00 p.m. at the latest if they are to arrive by 7:30 a.m. or 8:00 a.m. to begin work the next day.
- When the service is very busy, please make sure that rounds are completed with adequate time for the fellows to complete their duties within this time frame. (They do not have to stay late to dictate or write their notes. This can be done from home, and these hours do not count toward their 'in-hospital' time.)
- This does not necessarily pertain to the occasional on-call fellow who needs to come in to do endoscopy or evaluate a critical patient.

Liver Biopsy Trays

As of 4/7/03, Jamshidi soft liver biopsy trays are no longer stocked in the GI Procedures CD (Central Distribution) cart and are ordered on an "as needed" basis for liver biopsies performed in the GI Procedures Unit. If liver biopsies are done on the inpatient floors, the trays must be ordered by the floor. Our hepatologists report doing the majority of their inpatient liver biopsies on 5 East and 3 West. Prior to 4/03, hepatologists on the floor would come down to Procedures and take the Jamshidi liver biopsy trays to the floors to use on inpatients. However, because of charging and reimbursement issues, GI Procedures can no longer supply these trays for inpatient floor use. To this end, 5 East and 3 West have agreed to stock two trays on their CD cart at all times. These are restocked on a daily basis so if they are used, they are replaced. If more than two are used in one day, additional ones can be ordered STAT via computer through Central Distribution.

Ultrasound

The ultrasound machine is stored in Room 3232 (3 West), which has a combination lock. Use the following combination: 2 & 4 together, then press 3 alone. The nurse will page the doctor who is to perform the biopsy with the appropriate room number once the patient is prepped for biopsy.

Liver Transplantation Service

The liver transplant service is a multidisciplinary team that assesses and cares for patients who require liver transplantation and those who have received transplants. The transplant nurse coordinators manage the flow of clinical information on pre- and post-transplant patients. They are an excellent resource but are extremely busy. The liver fellow should not expect them to do all the “scut work” in caring for the liver transplant patients. The transplant social worker, Susan Cooper, assesses all patients for transplantation. In addition, she follows pre- and post-transplant patients with social difficulties. Dr. Donna Evon is a clinical psychologist who assesses prospective transplant patients with a history of substance abuse. She assesses and follows patients with a history of substance abuse and sets the conditions that patients with a history of substance abuse must meet in order to prove abstinence with the assistance of other members of the team. In addition, she follows transplant patients with psychiatric comorbidities but cannot prescribe medications. Ruthann Conoley and Bob Dupuis are the pharmacists affiliated with the liver transplant service. Leslie Spampinato is the dietician for the service.

Liver transplant selection conference takes place each Wednesday from 2:00 p.m. to 3:00 p.m. in the Transplant Clinic area on the fourth floor of the Old Clinic Building. You must attend this multidisciplinary conference because all of the inpatient liver transplant patients are discussed here. Moreover, discussions about the assessment and listing of outpatients for transplantation can be highly educational.

You will attend the portion of the morning abdominal transplant meeting pertaining to liver transplants. This meeting is held at 9:00 a.m. every Tuesday in the General Surgery Conference Room on the third floor of the Old Clinic Building.

You will attend the portion of the afternoon walk around abdominal transplant rounds pertaining to liver transplants. The rounds are conducted by the attending transplant surgeon with the assistance of the attending hepatologist. Rounds begin at 3:00 PM, generally in the SICU. The liver transplant patients may also be in the CCSD and on 5 West. Because of the variable number of in-house transplant patients and OR schedules, you should confirm the time and location of the rounds.

On the first and third Wednesday of every month from 12:30 p.m. to 1:30 p.m., there is a hepatobiliary transplant conference in the Aventis Conference Room on the first floor of the Cancer Hospital. This is a multidisciplinary conference on patients with complex hepatobiliary issues before and after liver transplantation. The liver fellow must attend this conference since management strategies are discussed here.

On the second and fourth Wednesday of every month from 1:00 p.m. to 2:00 p.m. there is a liver histopathology conference given by the Department of Surgical Pathology in their suite on the third floor (30149) of the Women’s Hospital (30208). All histology on liver biopsies and explanted livers is reviewed during this conference. The liver fellow should submit the names of all patients on whom liver biopsies have been performed within the preceding week. This conference is conducted by two of our liver pathologists and provides an excellent opportunity to learn about liver histology.

The list of tests used in outpatient liver transplant assessments will be provided when you begin the consult service. This should be used for in-house patients as well.

The liver fellow should work closely with one of the pretransplant coordinators to complete their pre-transplant evaluation and to determine the transplant status on patients who are

already on the UNOS (United Network of Organ Sharing) list. The liver fellow should inform the inpatient coordinator if any patients on the waiting list are admitted or discharged over the weekend or holidays so that she can notify the pre- and post-transplant coordinators of follow-up clinic visits.

When called to see a patient for the question of candidacy for transplantation, the liver fellow should not communicate ANY decision about transplant candidacy or status to a patient or a patient's family unless s/he has discussed this with the liver attending. Patients may have high expectations of being listed for transplantation, even if they are not suitable candidates. They are not well served by being deceived or by receiving conflicting messages from members of the transplant team. A list of the criteria for listing for transplantation and how to determine a patient's status will be provided to you when you begin the consult service. These are uniform rules developed by UNOS and are used across the country.

If possible, the liver fellow should try to attend the transplant surgeries for the patients s/he has followed in the hospital.

Important Persons and Phone Numbers for the Liver Transplant Service:

	Phone Number	Pager Number
Dr. Ken Andreoni (surgeon)	966-8008	1-888-515-2156
Dr. David Gerber (surgeon)	966-8008	1-888-714-0886
Dr. Jama Darling (medical hepatologist)	966-3739	216-4955
Dr. Michael Fried (medical hepatologist)	966-2516	216-2107
Dr. Paul "Skip" Hayashi (medical hepatologist)	966-2516	216-6113
Ruthann Conoley (pre-transplant physician assistant)	843-0422	216-0349
Susan Cooper (transplant social worker)	966-7865	123-4624
Bob Dupuis (transplant pharmacist)	966-6194	123-2159
Dr. Donna Evon (transplant psychologist)	966-2516	216-2405
Angela Fisher (inpatient post-transplant coordinator)	843-0524	347-1865
Connie Lipton (transplant nurse coordinator)	843-6311	216-1003
Amy Miller (post-transplant nurse coordinator/living donor coordinator)	966-6459	216-2755
Diane Roush (post-transplant coordinator)	966-3637	216-2465
Leslie Spampinato (transplant dietician)	843-0563	123-4214
Kimberly Thomas (pre-transplant coordinator)	966-9842	216-2095
Patricia Thompson (post-transplant nurse practitioner)	966-7090	216-0142
Jeanette Wilson (post-transplant nurse coordinator)	966-6214	347-1063
Judy Young (post-transplant coordinator)	966-3637	216-2465

Patients requiring financial assistance may contact our financial counselor, Ms. Nedra Lewis Owens, at 6-1124 (phone), 6-5697 (fax), or NLLewis@unch.unc.edu.

To make it easier to reach the transplant pharmacist responsible for clinic and consult patients, a pager is now available, which allows the residents, the transplant pharmacy (Bob Dupuis), and the pre-transplant physician assistant (Ruthann Conoley) to interchange services and/or responsibilities without confusion among the coordinators and housestaff. Please page this number with any drug information questions or questions-comments regarding off-service patients. The pager number is 123-7060, and it can be accessed through the hospital directory via WebExchange under “pharmacy transplant consults.”

Donor Services

UNC Hospitals and Carolina Donor Services have joined together to increase organ donor consent rates to 75% at our medical center, more than double the current rate of 31%. Carolina Donor Services, this region’s federally designated, nonprofit organ and tissue procurement organization, selected UNC Hospitals to take part in this national initiative, coordinated by the US Department of Health and Human Services. This collaborative effort is intended to increase significantly the number of lives saved through transplantation. One can learn more about organ donation in North Carolina by visiting www.carolinadonorservices.org.

In the United States, eligible donors become actual donors less than half of the time (46%). Most hospitals have donation rates of 30% to 55%, and some have rates as low as below 5%. However, some hospitals have achieved an outstanding organ donation rate of over 75%, due to the result of practices developed and used jointly by hospitals and organ procurement organizations to foster and facilitate the donor process. This specific collaborative will identify such practices and replicate them in hospitals throughout the country, hopefully to bring out increased donation rates.

More than 81,000 people in the US are on a waiting list to receive a life-saving organ. In 2002, 6,122 died while awaiting transplantation. Every 13 minutes, a new name is added to a transplant list. In North Carolina, 2,900 people are awaiting organ transplantation.

According to the UNOS annual report, in 2002 UNC had 400 patients on the waiting list for liver transplant, with past figures being: 12/93 – 15, 12/94 – 20, 12/95 – 40, 12/96 – 70, 12/97 – 120, 12/98 – 160, 12/99 – 250, 12/00 – 310, and 12/01 – 350, a markedly steady increase. The UNOS web site is <http://www.unos.org>. At UNC, 49 liver transplants were performed in 2002, with past figures being four in 1991, 11 in 1992, 18 in 1993, 39 in 1994, 37 in 1995, 33 in 1996, 50 in 1997, 65 in 1998, 64 in 1999, 74 in 2000, and 55 in 2001. For overall cadaveric liver transplantation outcomes post OLT nationally, success rate of survival of patients was 88% one year, 80% three years, and 75% five years; at UNC, these figures were 85%, 90% and 78%, respectively, for year 2001. As of 2007, UNC performs over 100 liver transplants per year. 1.4 million people seek treatment for hepatitis C in the US, and it is one of the top ten diseases responsible for mortality in the US. Failure to obtain organs for those waiting on the liver transplant list results in an average of 18 deaths per day. In our area alone, more than 100,000 cases of hepatitis have been identified.

There are 12 Centers in the US participating in an NIH multicenter trial on liver transplant patient/graft survival with pilot and cohort studies relating to clinical research and outcomes including biliary leaks and strictures, HCC, HCV, immunosuppression and sepsis in addition to donor status pre- and post-transplant. The web site is www.nih-a2all.org. Ongoing studies from other institutions pertain to HBV, cirrhosis and hepatorenal syndrome. In the growing areas of liver research, scientists have identified 25,000 genes for DNA genomics; 1,000,000 for RNA transcription; 250,000 proteins for proteomics; and 2,500 mini-molecules for serum metabonomics.

The site for the UNC Blood Drive is <http://www.sph.unc.edu/blood/>. The number for the platelet donor program is 6-2370.

Conferences and Organizations

Our subdivision of Hepatology (UNC Liver Program) has hosted our seventh annual ‘High-Impact Hepatology Symposium’ November 13 and 14 2009 at the Rizzo Conference Center, www.highimpact-hepatology.com. The format of this novel program consists of a series of roundtable discussions where participants and faculty can interact closely to share the latest approaches to the management of common liver diseases and to discuss several cutting-edge topics in the area of hepatology. This program is designed for healthcare professionals who manage patients with chronic liver diseases, including gastroenterologists/ hepatologists, nurse practitioners, and physician assistants. At this meeting, there has been one guest faculty member from outside of UNC. Past break-out sessions have included novel therapies for PBC, hepatotoxicity, ways to improve HCV therapy, challenging case presentations drawn from the archives of the UNC Liver Program, and controversies in hepatology. Last year’s topic focused on an update on clinical data from AASLD. We thank Amgen, Axcan, and Gilead Pharmaceuticals for their continued sponsorship of this important yearly symposium.

The Solid Organ Transplant Journal Club is held the first Thursday of each month from 10:00 a.m. to 11:00 a.m. in the Surgery Conference Room of the Old Clinic Building. Breakfast is provided. For more information contact Ruthann Conoley at RConoley@unch.unc.edu.

This year, Duke University has sponsored its seventh annual “Duke Liver Disease Update and Symposium” on Saturday, September 12, 2009 in the North Pavilion, Duke Clinical Research Institute (DCRI), with registration from 7:30 – 8:30 AM and the symposium from 8:30 AM – 3:00 PM. The Institute is located at 2424 Erwin Road, Suite 402, in Durham, NC 27705. The main objective of this one-day symposium is to provide practitioners with the latest information on therapies available for the most common liver diseases. The symposium features key national speakers discussing recent therapeutic advances in the treatment of HBV, imaging of the liver, portal hypertension, hepatocellular carcinoma, and chronic HCV. Dr. Muir, the conference organizer, has generously extended a free invitation to our trainees.

The email address for the American Transplant Congress is atc@ahint.com. The ATC sponsors a meeting during the last weekend of May through the first week of June each year. Abstract submission deadline is the end of the first week in December. The ATC is designed for physicians, nurses, scientists and organ procurement personnel interested in the clinical and research science of solid organ and tissue transplantation. This meeting provides the most current information in the field of transplant science and encourages the exchange of new scientific and clinical information about the care and management as well as the socioeconomic, ethical and regulatory issues relevant to organ and tissue transplantation. The goals and objectives of this meeting include

- Review and evaluate the latest clinical and basic science advances in transplantation science, medicine and surgery;
- Investigate recent developments in transplant biology, immunology and organ preservation;
- Examine the broad but critical issues in transplantation.

The University of Colorado School of Medicine invites fellows to participate in the ‘Hepatology Young Investigator’s Forum’ in Breckenridge, Colorado, during the first weekend of March, held in

conjunction with the ‘Controversies in Transplantation’ meeting sponsored by the University of Colorado SOM CME Office. Objectives for the Young Investigator’s Forum include

- establish a forum where research trainees orally present their original research in an adjudicated and instructional environment
- afford young investigators an opportunity to meet and exchange ideas with peers in hepatology research
- augment the ‘Controversies in Transplantation’ meeting with abstracts presented by research trainees and encourage future participation and support

The deadline for submission of abstracts is January 15. Fellows are encouraged to submit abstracts of original basic or clinical research. Priority is given to abstracts focusing on pathobiology or clinical science of hepatitis C relative to immunosuppression, immunopharmacology, transplantation, advanced liver disease, or advanced renal disease. Abstracts are rated by a panel of five faculty experts, and 20 abstracts are selected for presentation. The panel then assigns selected abstracts to either 15-minute oral presentations or posters. A single award for the most outstanding research is awarded at the forum.

Travel, room expenses, and registration for the ‘Controversies in Transplantation’ meeting are provided to fellows who have submitted selected abstracts via a generous, unrestricted educational grant from Amgen. Abstract forms are available on line at <http://www.uch.uchsc.edu/sotx>, via email jody.mandic@uchsc.edu, or by phone Jody @ 303-372-8731.

The Fellows’ Hepatology Update for 2009 is held the weekend of October 2-4 at the American Airlines Training and Conference Center in Fort Worth, Texas. The program begins Friday afternoon on October 2nd, allowing for Friday morning arrivals, and the program ends at mid-day on Sunday, October 4th, allowing a return home by late afternoon. An outstanding panel of thought leaders in the field of hepatology has been assembled for this symposium. The program consists of didactic lectures and discussion of case presentations. Attendees have the opportunity to interact with faculty during scheduled interactive sessions, including Q & A sessions, break-out sessions, and informal recreational and social activities. The program is intended for one senior fellow. This year, fellows need to register by Friday, July 31. Thanks to a generous grant from Roche Hepatology, the fellow who attends receives complimentary registration to this symposium. Expenses for air travel up to \$500 – only when booked through Crystal Travel – is also covered. In addition, two nights’ housing is secured and covered, along with meals for each attendee over the dates of the meeting. Travel grants are limited and are allotted on a first-come, first-served basis. For any questions, please contact Jeffrey S. Crippin, M.D., Co-Chair, Medical Director of Liver Transplantation at Washington University School of Medicine, jcrippin@wustl.edu. For meeting logistical questions, contact Tina C. Squillante, meeting manager, at tsquillante@ahint.com (ext. 4436). Mailing and other information includes: Fellows’ Hepatology Update 2007, 15000 Commerce Parkway, Suite C, Mt. Laurel, NJ 08054, phone 856-439-0500, fax 856-439-0525.

Also of note is the 15th annual Hepatobiliary Update, with an optional hepatology review for the GI boards, held from August 28 – September 4, 2009 at the Atlantis Hotel on Paradise Island in the Bahamas, presented by the Department of Medicine at Johns Hopkins and their CME program. One can register on line at www.hopkinscme.net, by phone 410-955-2959, or by fax 410-955-0807. The mailing address is Johns Hopkins University, Office of Continuing Medical Education, PO Box 64128, Baltimore, MD 21264-4128.

This course focuses on new developments in the management of liver and biliary diseases and liver transplantation. Many gastroenterologists have to retake the GI board examination every ten years, and liver questions comprise 30-40% of the examination. Thus, an optional part of the course helps physicians prepare for the GI board examination. This portion of the conference addresses portal hypertension, MELD scoring, acute liver failure, vascular complications, hemochromatosis, Wilson's and other metabolic diseases, HBV, HCV, HBV-HCV/HIV co-infection, liver transplantation and immunosuppression, autoimmune hepatitis and liver masses, vascular imaging, and MRCP.

Course objectives include

- Outline recent advances in portal hypertension and liver transplantation;
- Practice multi-modality management of hepatocellular carcinoma;
- Define optimal management of HBV and HCV;
- Describe new developments in liver and biliary imaging.

The course offers an array of hepatobiliary topics, including hilar strictures, MRCP, percutaneous intervention for bile duct strictures, PSC, surgical options for cholangiocarcinoma, mesenteric and portal vein thrombosis, variceal bleeding, ascites and hyponatremia, percutaneous management of complex portal hypertension, treatment of NASH, and the utility of non-histological markers of liver fibrosis.

MedOptions sponsors the Annual Clinical Care Options for Hepatitis Symposium the last weekend of June in Dana Point, California, touted as the most important clinically focused hepatitis meeting of the year, designed for experienced front-line primary care physicians, gastroenterologists, and infectious disease specialists providing care to patients with viral hepatitis. Topics include the immunopathogenesis of HBV and HCV, the most current data on HBV and HCV treatment, questions and controversies around HBV treatment guidelines, hepatocellular carcinoma, steatosis and HCV, cirrhosis, epidemiology of HCV, and interactive case challenges. For more information, contact MedOptions, CCOHEP Symposium, 7 West 36th Street, 10th Floor, New York, NY 10018.

This past year The Scripps Research Institute has held its 4th annual conference on 'New Advances in Solid Organ Transplantation', which provides a comprehensive learning experience where experts in transplant management present cutting-edge research and teach practical knowledge for the care provider to take back and implement into his or her practice. Educational objectives include:

- Describe how an organ is rejected and new immunosuppressive strategies for solid organ transplantation;
- Recognize post-transplant strategies challenges in the allograft and recipient;
- Discuss hepatitis management pre- and post-transplantation and where living-related liver donation is considered as a treatment option;
- Recognize ethical issues in transplantation when advocating for your patient to be transplanted.

For information about this conference, please contact Julie Simper at 858-882-8456 (fax 858-882-8466) or email med.edu@scrippsclinic.com. Interested individuals can visit www.scrippsclinic.com. The American Liver Foundation is a non-profit, national voluntary health organization dedicated to the prevention, treatment, and cure of hepatitis and other liver diseases through research, education and advocacy. The ALF has been grateful enough to receive unrestricted educational grants from Axcan Scandipharm. The Foundation's phone numbers include 1-800-465-4837 and 1-888-443-7222; email info@liverfoundation.org; website www.liverfoundation.org.

“Hepatology Watch” is a monthly newsletter produced by the Market Development Group through an educational grant from Roche Pharmaceuticals. If you are interested in receiving this monthly newsletter, please visit <http://www.hepwatch.com>. UNOS *Update* is a news magazine for the transplant community. Visit their site at www.unos.org. Headquarters are located at 700 North 4th Street, Richmond, VA 23219 (PO Box 2484, Richmond, VA 23218), phone 804-782-4800, fax 804-782-4817.

CRITICAL APPRAISAL OF THE MEDICAL LITERATURE

The ability to critically evaluate the medical literature is an important skill - one of the most important skills that that one can acquire. There are certain methodologic criteria to assess whether an article represents an important advance in treatment, prevention, diagnosis, cause, or prognosis, or whether certain flaws make the findings suspect. The following guidelines were adapted from the following source: Sackett DL, Haynes, RB, Tugwell, P *Clinical epidemiology: a basic science for clinical medicine*. Boston: Little Brown and Company, 1985. The “Purpose and Procedures” of the ACP Journal Club also includes a careful description of methodologically sound articles.

For more information about critical appraisal and evidence based medicine check the following:
http://www.cche.net/principles/content_all.asp

I. Four rules for reading clinical journals

1. *Look at the title.* Is it potentially interesting or possibly useful in your practice?
2. *Review the list of authors.* Is the track record of the authors (if you know it) one of careful thoughtful work that has stood the test of time? (If track record unknown proceed to 3)
3. *Read the summary.* Would the conclusion, if valid, be important to you as a clinician?
4. *Consider the site.* Is the site sufficiently similar to your own that its results, if valid, would apply to patients in your practice?
 - a. Is your access to the required facilities, expertise and technology sufficient to allow you to implement the maneuvers described in the article?
 - b. Are the patients seen in the facility where the article was written likely to be similar to your patients in disease severity, treatment, age, sex, race or other key features that have an important bearing on clinical outcomes?

II. Methodologic criteria for the critical assessment of an article on PROGNOSIS

1. *Was an inception cohort assembled?* Were patients identified at an early and uniform point in the course of their disease? Were the diagnostic criteria, disease severity, comorbidity and demographic details for inclusion clearly specified?
2. *Was the referral pattern described?*
3. *Was complete follow-up achieved?* Were all patients entered in the study accounted for in the results? Was their clinical status known?
4. *Were objective outcome criteria developed and used?* Are the criteria reproducible and accurate?
5. *Was outcome assessment blind?*
6. *Was adjustment for extraneous prognostic factors carried out?*

III. Methodologic criteria for the critical assessment of an article on THERAPY

1. *Was the assignment of patients to treatments really randomized?* Was similarity between groups documented? Were patients with poor prognosis assigned equally?
2. *Were all clinically relevant outcomes reported?* Was morbidity as well as mortality reported? Were deaths from all causes reported? Were quality of life assessments conducted? Was outcome assessment blind?
3. *Were the study patients recognizably similar to your own?* Are reproducibly defined exclusion criteria stated? Was the setting primary, secondary, or tertiary care?
4. *Were both statistical and clinical significance considered?* If statistically significant, was the difference clinically important? If not statistically significant, was the study big enough to show a clinically important difference if it should occur (type II error)?
5. *Is the therapeutic maneuver feasible in your practice?* Available, affordable, sensible? Did patients in the control group receive the intervention? Did patients in the treatment group avoid the intervention? Was the maneuver administered in a blind fashion? Was compliance measured?
6. *Were all patients who entered the study accounted for at its conclusion?* Were drop-outs, withdrawals, non-compliers, and those who crossed over handled appropriately in the analysis? Was an intention-to-treat analysis conducted, or was the analysis restricted to those who actually completed the therapy?

IV. Methodologic criteria for appraising journal articles about DIAGNOSTIC TESTS.

1. Was there an independent, "blind" comparison with a "gold standard" of diagnosis?
2. Was the setting of the study, as well as the filter through which the study patients passed, adequately described?
3. Did the patient sample include an appropriate spectrum of mild and severe, treated and untreated disease, plus individuals with different, but commonly confused, disorders?
4. Were the tactics for carrying out the test described in sufficient detail to permit their exact replication?
5. Was the reproducibility of the test result (precision) and its interpretation (observer variation) determined?
6. Was the term "normal" defined sensibly?
7. If the test is advocated as part of a cluster or sequence of tests, was its contribution to the overall validity of the cluster or sequence determined?
8. Was the "utility" of the test determined? (Were patients really better off for it?)

V. Methodologic criteria for CAUSATION

1. Is there evidence from true *experiments* (randomized controlled trials) in humans? Observational studies (in decreasing order of validity) provide less convincing proof - cohort study; case-control study; descriptive study (case report, case series).
2. Is the association *strong*? The higher the relative risk (or odds ratio), the stronger the association.
3. Is the association *consistent* from study to study? Repetitive demonstration by different investigators of an association between exposure to the putative cause and the outcome of interest using different strategies and in different settings.
4. Is the *temporal relationship* correct? Did the purported exposure clearly come before the outcome of interest? [Did *H. pylori* precede the duodenal ulcer or did it colonize an ulcer already present?]
5. Is there a *dose-response* relationship? Demonstration of increasing (decreasing) risk of severity of the outcome of interest in association with an increasing (decreasing) "dose" or duration of exposure to the putative cause. [If smoking causes lung cancer, heavier smokers (higher dose) should have greater risk of lung cancer.]
6. Does the association make *epidemiologic* sense? Results in agreement with our current understanding of the distributions of causes and outcomes?
7. Does the association make *biologic* sense? Association agrees with our current understanding of the responses of cells, tissues, organs and organisms to stimuli. [Remember that convincing epidemiologic findings may precede our understanding of the biology - we knew that contaminated water transmitted cholera before Koch identified the cholera bacillus.]
8. Is the association *specific*? The limitation of the association to a single putative cause and a single effect. [Aflatoxin causes liver cancer but not lung, bladder, pancreatic cancer - the effect is *specific* to the liver.]
9. Is the association *analogous* to a previously proven causal association?

Users' Guides to Reading the Medical Literature

1. Oxman AD, Sackett DL, Guyatt GH: Users' guides to the medical literature. I. How to get started. The Evidence-Based Medicine Working Group. *JAMA* 1993;270:2093-2095.
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RESEARCH RESOURCES

ABIM Research Pathway

The ABIM research pathway for board certification in internal medicine and gastroenterology is a full seven-year program (84 months) consisting of 24 months of internal medicine residency, at least 18 months of accredited clinical gastroenterology fellowship training and 36-42 months of research. Research time depends on amount of clinical time: for example, 18 months of clinical work would require 42 months of research. 24 months of clinical time would require 36 months of research, for a total of 60 months in gastroenterology. However, a physician may be able to sit for the GI board exam through the ABIM research pathway if the additional research year is in the capacity of a full-time faculty member, with 80% commitment to mentored research. Fast track fellows can no longer take IM boards during their PGY 3 year but must wait until their PGY 4 year. Consideration for this pathway involves advanced planning and must be made no later than the spring of the PGY2 year.

CONFERENCES

The Association of American Medical Colleges (AAMC) holds its Annual Research in Medical Education Conference during the second week of November in Washington, DC. The deadline for submission of papers is March 14; submission guidelines and forms are available at <http://www.aamc.org/members/gea/rime/start.htm>. For information, one may contact Caroline Ford Coleman, ccoletman@aamc.org, 202-828-0412. The AAMC publishes *Academic Medicine*, www.academicmedicine.org. The Association of Professors of Medicine (APM) publishes *The American Journal of Medicine*, www.amjmed.com.

The Southern Medical Association (SMA) holds its Annual Scientific Assembly the first weekend of November in Atlanta, Georgia, and invites residents to submit abstracts. The SMA accepts 300 abstracts for either oral or poster presentation as part of their continuing commitment to training. All medical students, residents and fellows are encouraged to submit an abstract for presentation. This is a wonderful opportunity for trainees to share their clinical experiences and interact with peers while gaining valuable medical knowledge. There is no registration fee, and participation includes free SMA membership, which includes access to the *Southern Medical Journal* on line. In addition, there are no restrictions: presentations made at the SMA meeting may also be presented elsewhere. Accepted abstracts for oral presentation are published in the October issue of the *Southern Medical Journal* on line. Submission deadline is April 4. For questions, please call Wendy Ried Dembowski at the SMA headquarters office at 1-800-423-4992 ext. 150 or email her at wendy@sma.org.

This year the AGA held its 12th annual 'Methodologies in Healthcare Outcomes in Gastroenterology: A Workshop Symposium' on November 13-14 in Chicago. Study and poster presentations were featured and allowed participants to:

- Gain hands-on experience in outcomes study methodologies;
- Learn to design a scientifically sound clinical study;
- Generate meaningful outcomes with direct applicability to clinical medicine and to the practicing gastroenterologist.

Space for this conference is limited, so early registration is encouraged by visiting www.gastroresearch.org. The pre-registration deadline for this year was October 4.

Each January for four days (usually the Thursday and Friday before the third weekend of January) the Evidence-Based Medicine Workshop for Gastroenterology Trainees in Scottsdale, Arizona, is held at the Scottsdale Conference Resort, sponsored by the Foundation for Evidence Based Medicine Education. It is important that each attendee—from our institution an epidemiology fellow—read the articles contained in the program workbook prior to the meeting, as they are discussed in detail during the conference. An attendee is expected to attend all events, including meal functions, in their entirety. Guests cannot be accommodated since this is a program focused on education. For more information, visit <http://www.ebmfoundation.org>, phone 714-279-1500, fax 714-279-7994. This conference has received positive feedback from past epidemiology fellows who have attended it.

This program consists of both general session lectures and interactive small group workshops. During the sessions and workshops, current issues and articles are reviewed utilizing Evidence-Based Medicine principles. The general session introduces clinical scenarios and review about the EBM framework for the critical appraisal of the medical literature for articles about therapy, diagnosis, harm, and systematic reviews. In the small group workshops, discussion is focused on the EBM approach to questions raised in the clinical scenario and critically appraise selected research articles using EBM principles. These workshops are led by experts in the field of EBM and gastroenterology research. The tenets of EBM provide a powerful lifelong tool for gastroenterologists to provide the best care for their patients. The purpose of this workshop is to provide the basics of EBM so that the fellow can go back to his or her institution and instill in his or her colleagues an appreciation of what EBM can do.

The annual McMaster Workshop held each June is a venue open to young epidemiologists who are pursuing a career in academic medicine. The Foundation for Evidence Based Medicine Education provides scholarships to attendees for travel expenses and tuition. Interested individuals should forward their CV to Walter L. Peterson, M.D., for his review. Dr. Peterson is co-editor of *Alimentary Pharmacology & Therapeutics* and senior partner for Evidence Based Medicine, LLC. Mailing address is PO Box 1845, Breckenridge, CO 80424, office phone 1-970-547-2995, mobile phone 1-970-485-2410, fax 1-970-453-5745. Email correspondence can be sent to Kym La Gattuta @ klagattuta@ebmed.com or to Dr. Peterson at wpetersonmd@cs.com.

In October of each year, there is a Healthcare Leadership Forum at the Joseph S. Koury Convention Center in Greensboro, NC. One can register online at www.mrnc.org or contact Medical Review of North Carolina at 800-682-2650, ext. 2004.

On May 15-16 of this year, the Advisory Board Company offered *Boot Camp: Leadership Fundamentals for Physicians*, convening at The Ritz-Carlton in Lake Las Vegas. This two-day seminar aims to prepare physicians to succeed in hospital leadership roles and provide a comprehensive business orientation for them. This year's seminar was limited to 125 participants, with up to 15 CME credits available for participation. Registration rates ranged from \$1750 per individual to \$5500 for a team of four. The dedicated web site is www.physicianbootcamp.com. Complete contact information includes 202-266-5451 or 888-263-5451 (toll), email physicianbootcamp@advisory.com. Advisory Board Academies are located at 2445 M Street, NW, Washington, DC 20037.

In January 5-9 of this year, Professor Michael S. Porter of the Harvard Business School offered a 'Value-Based Health Care Delivery Immersion Course' for Harvard and non-Harvard MBA and MD

students; graduate students; residents and junior physicians with interest and experience in health care delivery. For a course overview, see http://www.isc.hbs.edu/pdf/HC_Immersion_Schedule_2008.pdf. Non-HBS applicants were asked to apply by 5 PM on Monday, November 3, 2008. Please contact the ISC Programs Coordinator, Kathleen Custodio (kcustodio@hbs.edu) with logistical questions about the course and how to apply online. For more information on the health care curriculum being developed at ISC, see http://www.hbs.edu/rhc/health_care_delivery_curriculum.html or contact Jennifer Baron, ISC Senior Researcher (jebaron@hbs.edu).

Each year the Medical College of Wisconsin offers a 1.5 day conference for GI fellows (20 selected) and internal medicine residents expressing interest in GI (10 selected) who are interested in academic medicine. This program has had resounding positive feedback, with objectives including to promote and enhance enthusiasm about academic GI as a career, to familiarize potential candidates with the responsibility and privileges of joining the rank of educators of the next generation of GI specialists, and to provide candidates with a network of colleagues for future interactions and an exchange of information and ideas. All travel expenses, lodging, meals and educational material are covered through an educational grant from AstraZeneca. Interested individuals should contact Dr. Reza Shaker at 414-955-6766 (fax 414-955-6215).

The UNC Program on Integrative Medicine presents an ongoing seminar series the first and third Fridays of each month from 12:30-1:30 p.m. in the fifth floor Department of Medicine conference room (5032) in the Old Clinic Building. For more information, go to <http://pim.med.unc.edu> or call 6-8586.

Our Center for Gastrointestinal Biology and Disease (CGIBD) holds an annual Pilot/Feasibility Competition each spring. Any investigator who is a member or is sponsored by a member of the UNC CGIBD is eligible to apply for funding for a pilot project related to digestive disease research in the amount of \$30,000. Letters of intent are due in February, and full applications are due in March. Finalists are asked to make an oral presentation to our Scientific Review Committee. Applicants should use the forms and follow the directions found on the CGIBD website at <http://giadmin.med.unc.edu/cgibd/pilot.html>. In particular, lab directors are encouraged to bring this to the attention of members of their lab. For questions, contact Evan Ellis-Raymer at 6-8381, eraymer@med.unc.edu. Similarly, lab members are encouraged to participate in our annual Research Competition Day held in the fall, the winner of which receives \$1,000.

Our CGIBD holds its annual Scientific Retreat in June. There is a keynote speaker with a lunchtime poster session, during which winners of our pilot and feasibility awards from the previous year present the results of their research. Posters are judged by peer faculty members. Attendees have an opportunity to interact with members of the Center's Review Committee. For more information regarding this retreat, please contact Fern Jeremiah at 3-0758 or email her at Fern_Jeremiah@med.unc.edu. We also provide a DDW Practice Session, generally on a Thursday two weeks prior to DDW, for anyone who plans to present a research talk at this national conference. Participating in this practice can achieve two goals: individuals have a chance to receive constructive feedback from a friendly and encouraging audience; second, the practice talk gives those who might not hear the talk a chance to learn ongoing research from their colleagues. Past participants have found this session extremely valuable in helping them refine their presentations.

CONTINUING EDUCATION

The UNC Office of Training & Development offers courses throughout the year including American Sign Language (ASL) and varying levels of Spanish. Online registration can be completed by going to <http://www.training.unc.edu>. For questions please call 2-2550.

Epidemiology 230 – Molecular Epidemiology Techniques course uses infectious, cancer, and cardiovascular diseases as models; molecular and genetic techniques are discussed and applied toward understanding environmental and genetic factors in the development of complex diseases in populations. This course provides an overall of techniques used such as PCR and flow cytometry. One can contact Dr. David Ransohoff (ransohof@med.unc.edu) for more information.

There is a program called “Episheet” by going to <http://members.aol.com/krothman/modempi.htm>. This web address actually takes you to the homepage for a textbook, Modern Epidemiology. On this page there is a link that says “Download Episheet.” Click on this, which opens the Episheet program in Excel. You must put security on ‘low’ for the spreadsheets to work properly. This can be done by going to ‘Tools’ – ‘Macros’ – ‘Security’. This is an efficient way to do statistical calculations for epidemiological research.

The UNC Health Care Learning Management System (LMS) is a web-based application for required courses, class schedules, registration, and information about the various training programs available to you. Your personal learning information is organized into six categories to help you manage your career development:

- My Learning Plan: Courses you need to take because of job requirements or because they have been added to your plan.
- My Assigned Curricula: Program titles with a set of courses assigned to you because of job requirements.
- My Calendar: A month-to-month view of classes in which you are enrolled.
- My Profile: Information that defines you as a user of the UNC Health Care LMS Student Center.
- My Online Courses: A list of online courses you have started but not finished.
- My Transcript: Courses and classes for which you have enrolled or finished.

Log on instructions to LMS outside the UNC Health Care System:

- Open a browser using Internet Explorer.
- Type this URL in the Address field: <https://lmsweb.unch.unc.edu>.
- Log onto the LMS with your SSN (no dashes) as the user ID and the last six digits of your SSN as your password.
- Change your password following the instructions of the ‘Change Password’ screen.

Ways to log on within the UNC Health Care System:

- Go to <http://lmsweb.unch.unc.edu>.
- Go to Intranet@Work at <http://www.unch.unc.edu> and click on ‘My Student Center’.
- Enter lmsweb in the IE browser address.
- Click on the ‘lmsweb shortcut’, which is a little red schoolhouse, from any clinical work station.

Completion of Required Learning:

- Click on ‘My Assigned Learning’ and look for the Programs assigned to you for your completion.

- Click on the Program Title for the individual Courses in the Program you are required to complete.
- Read the course information and instructions to complete the course and/or assessment for completion on your Transcript.
- Some courses are Instructor-Led, and you may already be scheduled into a class. Go to 'My Calendar' to view your classes as scheduled.

Tips on Using the LMS:

- Take the online Tutorial.
- Refer to the FAQ (Frequently Asked Questions) document.
- Refer to the Glossary found in Student Resources.

THE FRIDAY CENTER FOR CONTINUING EDUCATION offers courses online, part-time continuing studies, independent studies, and self-paced study online. In addition to these services and study modules, the Friday Center sponsors a series of continuing education specifically geared for health sciences, including the School of Public Health (Bill Browder, bill_browder@unc.edu, 6-4434), School of Medicine (Deedra Donley, deedra_donley@med.unc.edu, 2-8886), and Area Health Education Centers (AHEC) Support (Tony Kane, tony_kane@med.unc.edu, 6-0804, <http://www.ncahec.net>). You can visit the Friday Center site at www.fridaycenter.unc.edu or call 2-1134 (fax 2-5549). Tim Sanford is the Associate Director; he can be reached at 2-2644 or tim_sanford@unc.edu.

The Translational Medicine Graduate Program offers a stem cell and regenerative medicine track. Contact Patrick Brandt, Ph.D., Director of Science Training and Diversity at UNC: pdbrandt@email.unc.edu, 3-9342, 1120 Bioinformatics; <http://www.med.unc.edu/oge/stad/about-us>.

DATABASES

GlaxoSmithKline (GSK) has rights for three large databases: GPRD (General Practitioner Research Database), IMS Lifelink, and IHCIS (Integrated Healthcare Insurance Solutions). GSK has expressed interest in collaborating with us on research protocols for basic epidemiologic, health services, and pharmacoepidemiologic studies. We can present ideas; if it is within the realm of interest, they provide the data and the analyst support, if so desired. In the end, we produce some high-quality papers together, efficiently and inexpensively. GSK's particular areas of GI interest include GERD, dyspepsia, IBS, IBD, constipation, fecal incontinence, and visceral pain, as they relate to current drugs and drugs in the pipeline, but have reiterated their broad research interest in advancing GI epidemiology, even in areas not tied to a particular drug. For more information concerning the use GSK's database in collaboration with UNC GI research projects, contact Rachel E. Williams, M.S., Ph.D., 919-483-1754 (phone), 919-315-4947 (fax), email rachel.e.williams@gsk.com. The GSK website is <http://www.gsk.com>. For information on biomedical data sciences, visit <http://www.biometrics.com>. There is a national web site now where papers published related to pharmaceutical clinical trials are posted <http://www.clinicaltrials.gov>. Before publishing, it would be wise to check this site because some affiliates accept papers only from those entities listed on the site. This site also cites project articles and where they are in the review process. This site was created in large part because of certain publications not getting out to the public, either because article projects of value may have been overlooked for publication, or those considered negative were rejected for publication, though such papers may contain valuable information.

UNC has two central repositories, the first of which is 'GrantSource Library'. This is a research funding database. When using it, make sure to refine your key word to make it as specific as possible. You can always broaden the search; however, if you begin with a general term, you may not be able to take full advantage of this highly recommended resource. The URL for 'GrantSource' is <http://research.unc.edu/grantsource/faculty.html>.

A second and newly established database should be of particular interest to beginning investigators and/or to investigators who are initiating small projects in an entirely new area. UNC has developed a searchable database that includes internal sources of funds available throughout the university. This database contains funding opportunities available for research and scholarly activities conducted by faculty, staff, postdoctoral fellows and students. Also included in this database are the many research-oriented awards and prizes administered by the university in addition to the internal application process (although most are funded by external sponsors). Some awards require nomination by a faculty member, center director or division chief/department chairman. The URL for this site is <http://cfx.research.unc.edu/funding/index.cfm>. Community of Science (COS) funding opportunities can be found at <http://www.gastro.org/wmspage.cfm?parm1=4544>.

The Incidence and Prevalence Database (IPD) is a cost-effective tool that saves researchers valuable time and effort locating epidemiology-related information, statistics, and sources. The IPD contains data that will answer many epidemiology-related questions about diseases, general healthcare, and procedures, all in a searchable online database. Researchers can browse thousands of articles each month looking for data to include in the IPD. From this large volume of articles, the researchers hand-select epidemiology-related texts, resulting in an intuitive, specific, customized database. The researcher can also browse back issues for additional articles of interest. For more information on this tool, go to http://www.researchandmarkets.com/product/da8385/the_incidence_and_prevalence_database_global or email Laura Wood, senior manager of Research and Markets, Ltd., at laura.wood@researchandmarkets.com.

We have an opportunity to obtain SEER-Medicare data. SEER data has been used to examine age- and race-specific trends in the incidence of cancer. It appears that all cancer types are put together; for example, all UGI cancers are together in one site-specific module, then coded by site, followed by type, grade and stage. Esophageal is coded by the third portion of the esophagus involved (proximal, mid, distal); stomach is coded by entry, such as cardia. Data is comprehensive and assumed to be of high quality: <http://jco.ascopubs.org/cgi/reprint/JCO.2008.20.7753v1>. Also, SEER morphology is coded by ICD-0-3: <http://training.seer.cancer.gov/biliary/abstract-code-stage/morphology.html>.

The Initial National Priorities for Comparative Effectiveness Research can be found at <http://www.iom.edu/CMS/3809/63608/71025.aspx>. The Federal Coordinating Council for Comparative Effectiveness Research report (6/30/09) can be found at <http://www.hhs.gov/recovery/programs/cer/cerannualrpt.pdf>.

UNC now has a File Upload tool where researchers can load documents for cross-sharing of information among labs. There is a limit of seven days for storage, however. The link is <http://www.med.unc.edu/www/administration/infotech/tools>.

FELLOWS

Incoming research fellows paid from our NIH training grants, as part of their research training with us, are required (per NIH policy) to take a formal ethics course, "Responsible Conduct in Research"

offered for a week (5 days from 8 AM – 12 PM) in the Molecular Biomedical Research Building (MBRB), over the summer in July. (The on-line mini-course does not suffice for this.) Those who miss the first year must arrange to take it before their second year of research. Those who have already taken this course do not need to do so again, as long as documentation is provided. Research fellows paid from non-NIH sources are expected to fulfill this obligation as well. This course covers issues pertaining to ethics of animal and human subjects; ethics of data acquisition; sharing and ownership of data; mentor and trainee responsibilities; ethics of publication practices; collaboration and peer review; informed consent; research misconduct; and conflict of interest. The incoming research fellow must be made aware of this requirement and can speak in detail about it to the faculty member directing his or her research. Another highly recommended course, “Introduction to Methods in Clinical Research,” focuses on research design. Both courses are offered by our Translational and Clinical Sciences (TraCS) Institute. We pay for the course fee (\$50) and for the course booklet. Fellows receive a certificate of completion. Checks should be made payable to the ‘University of North Carolina at Chapel Hill’ and mailed to ‘NC TraCS Accounting, 160 N. Medical Drive, Brinkhous-Bullitt Building, 2nd Floor, CB 7064, Chapel Hill, NC 27599-7064.’ Please note the course title and date in the memo section of the check.

Dr. David Weber of our Division of Infectious Disease teaches these courses. You may contact him about course details by email dweber@unch.unc.edu, pager 347-0639, direct office phone 3-0868, or at hospital occupational health (where he spends a great deal of time) at 6-4480.

Specifically, the Responsible Conduct of Research course is a one-week course organized and taught by Dr. David Weber, MD, MPH, Director of the NC TraCS Institute Regulatory Core. The course covers all NIH-required topics for the first phase of responsible conduct of research training. The course emphasizes the bounds of acceptable conduct including ethical use of animals in research, ethical treatment of human subjects, and conflicts of interest. Through the use of a number of case studies drawn from *Scientific Integrity* (Francis Macrina, ed. ASM Press, Washington DC, 1995) and *Teaching the Responsible Conduct of Research through a Case Study Approach* (Association of American Colleges, 1994), the students themselves are very much involved in the teaching process.

Susan Pusek is the Director of Education and Training Programs at our TraCS Institute. You may also contact her about course details by email suspusek@med.unc.edu or at 6-0128.

Because training in “Responsible Conduct in Research” (RCR) is mandated by federal granting programs, and because this course offering through TraCS is limited during the year, our Office of Postdoctoral Affairs offers a course that satisfies the RCR training requirement for the NIH. The primary goal for this course is to address RCR topics such as publication practices and responsible authorship, mentor/trainee responsibilities, research misconduct, and effective communication skills, including management of difficult conversations. The instructor familiarizes postdoctoral trainees with offices on campus where they can get assistance. Upon completing this basic training seminar, postdoctoral scholars have the opportunity to teach the ethics course to graduate students and lead discussion sessions. The course meets for three (3) sessions in the Sonja Haynes Stone Center’s Hitchcock Multipurpose Room 111. You must attend all three sessions to fulfill requirements for the certificate. Breakfast is provided each morning. For course information, please contact the Office of Postdoctoral Affairs at 2-9982.

If your research involves animals, you must visit <http://research.unc.edu/iacuc/index.php>, the web site for our Institutional Animal and Use Committee (IACUC).

As of March 15, 2005, a new training program for research involving human subjects has been implemented by the Office of Human Research Ethics (OHRE). This training, called CITI (Collaborative IRB Training Initiative), is required of all faculty, staff and students engaged in the

planning, conduct, or analysis of research at UNC-Chapel Hill involving the participation of human subjects.

This new training is in the form of a series of modules. You must register for the course, read the required modules, and take the various tests. You must obtain a 75% or better score for each module in order to obtain a certificate. Since this testing takes on average three hours to complete, you can take the modules one at a time and return to them when you have the next opportunity. As this constitutes a major investment of time, you are strongly urged to begin testing if you need to do so. All individuals listed on grants must pass this course to be listed on the IRB submission, and certificates need to be produced prior to initial funding.

The web page is <http://research.unc.edu/ohre/educ.php>. Individuals certified appear automatically in a database available for you to check your certification. The Research Ethics Training Database is located at http://cfx3.research.unc.edu/training_comp/.

Also, in terms of research, fellows may wish to refer to our Odom Institute for Research in Social Sciences located in 107 Manning Hall, phone 2-3061, fax 2-4777. Research fellows are urged to take the IRB research test, found at <http://cme.cancer.gov/c01/>. After completing this exam, print out your certificate and email verification that you took and passed the test and notify Dr. Nicholas Shaheen (nshaheen@med.unc.edu) so that he or his assistant can list you in the IRB research database.

It is mandatory that all incoming research fellows paid from our training grant see Evan Ellis-Raymer, our training grant coordinator, to complete necessary paperwork for appointment or reappointment to the grant. Evan is located in 4108 Bioinformatics; phone 6-8381, fax 6-7592; email eraymer@med.unc.edu.

FUNDING

The National Institute of Diabetes & Digestive & Kidney Diseases offers research funding opportunities in clinical research affiliated with the NIDDK laboratories and provides health information on diabetes and nutrition and on digestive, endocrine, metabolic, hematologic, renal and urologic disorders, both in English and in Spanish. The URL is <http://www.niddk.nih.gov/>. Researchers may also refer to Medscape, <http://www.gastroenterology.medscape.com>, www.med-source.com, and to our UNCLE resources of Health Sciences Library. One can track publications by going to www.pubmed.com. The National Library of Medicine (NLM) has a consumer health site, Medline Plus, <http://www.nlm.nih.gov/medlineplus/>, which houses extensive information on over 650 health conditions.

The American Medical Association (AMA) Foundation, the philanthropic arm of the AMA, annual supports a number of programs and scholarships specifically designed for residents and medical students. The Foundation recently distributed more than \$100,000 in grants to support medical research programs led by residents and students through its Seed Grant Research Program. This program awards grants of \$1,500 to \$2,500 to medical students and residents for conducting small projects in applied and clinical research. Deadline for applications for each funding cycle for the Seed Grant Research Program is November 15, with grants being awarded on February 20. For more information or an application form for this award, please visit <http://www.amafoundation.org>. One can also email questions to seedgrants@ama-assn.org or call 312-464-4200. The AMA publishes *American Medical News*, www.amednews.com.

Each year senior fellows and junior faculty members are encouraged to apply for a REGAL Award (Research Excellence in GI and Liver) sponsored by the University of Kansas Medical Center Continuing Education through a grant from Janssen Ortho-McNeil Primary Care, Centocor, and InScope. Applicants must demonstrate the ability to conduct research in the areas of upper GI, lower GI, outcomes, endoscopy, or hepatobiliary research. Criteria include submission of a published article from the last five years or an in-press research paper with the acceptance letter. Up to 20 winners are selected, each of whom receive a cash award of \$5,000 in addition to travel and lodging to attend the annual symposium in San Francisco, CA. Selected applicants must attend this symposium and present their research in the form of a ten-minute presentation. Only one applicant is chosen from each institution. For more information, contact Stephen Mosley, Ph.D. of Brookfield Resources, LLC – office: 215-493-1507, cell: 215-534-5184; fax: 215-493-2644; email: REGAL@brxcom.com.

Each year The GlaxoSmithKline Institute for Digestive Health (GIDH) grants research awards, due by December 3. We have had a research fellow participate in this award process. For information regarding GIDH research awards, please visit www.gidh.com or contact Barbara Rivera at 919-483-2826 or via email at Barbara.M.Rivera@gsk.com.

The UNC Program on Integrative Medicine in conjunction with the North Carolina Academic Alliance for Integrative Medicine offer pilot funding for research or educational projects to students, residents or fellows in any health-related professional training programs at Duke, East Carolina University, UNC, or Wake Forest University. Applications are due in mid March; projects must be completed by March 1 of the following year, with a maximum budget of \$3,000. Questions about this program can be directed to Kathi J. Kemper, M.D., M.P.H. at Wake Forest University SOM, 336-716-1292 or to Sally Norton, M.P.H., UNC Program on Integrative Medicine, 6-8586.

GRANT AND MANUSCRIPT PREPARATION

Each February our Department of Medicine sponsors a grant writing seminar for biomedical researchers, made possible by an unrestricted grant by Pfizer Global Pharmaceuticals. This seminar addresses both the conceptual and practical aspects associated with the grant-writing process. This is not a 'how to fill out forms' seminar, but rather one emphasizing idea development, how to write for reviewers, as well as tips and strategies for writing to improve success rate. This seminar has had an overwhelmingly positive response by past participants.

****Graduate Funding 101****

This series of workshops is co-sponsored by The Graduate School, The GrantSource Library, the University Library, and the Writing Center. The workshops are offered separately for students in the humanities and social sciences and students in the sciences and health sciences.

Workshop 1: Funding Sources and Fellowships Panel

Whether you are working on your dissertation or just starting graduate study, the place to begin your search for funding is the GrantSource Library. This session will provide an introduction to the library's resources and services, as well as effective strategies for conducting a funding search. Participants will be introduced to funding opportunity databases, customized funding alerts, and other print and electronic resources which are helpful in getting a good start in the search for funding. The second part of this workshop will feature a panel of prestigious external fellowship winners. Panelists will share their tips for success and answer questions from students.

Workshop 2: Literature Review and Proposal Writing

Effective writing strategies are an important of your proposal. This workshop will walk participants

through the proposal writing process, offering strategies for pre-writing, writing, and revising your proposals as painlessly and efficiently as possible. An adequate literature review can put the proposed project in the appropriate context for the application reviewers. The second part of this workshop will examine several online search techniques that can help ensure that you are finding the best resources possible to make your proposal convincing.

Information concerning these workshops can be directed to Megan Halsband of the GrantSource Library at gs@unc.edu. Workshop 1 registration can be viewed at http://cfx.research.unc.edu/gs_classreg/browse_single.cfm?event_id=150 (or 152); Workshop 2 registration can be viewed at http://cfx.research.unc.edu/gs_classreg/browse_single.cfm?event_id=151 (or 153).

Our School of Medicine has created a web site known as C.T.S.A. (Clinical Translational Science Award), located at <http://ctsa.unc.edu/>. C.T.S.A. provides a comprehensive resource for the grant application process. Major topics covered in the application include CTSA structure and governance; research education, training, and career development; participant and clinical interaction resources; protocol designs and biostatistics; regulatory knowledge and support; community engagement and research; translational technologies and resources; development of novel clinical and translational methodologies; pilot and collaborative translational and clinical studies; genomics; health policy; evaluation and tracking; milestones and implementation; ethics; and biomedical informatics. At this site, there is a link to an NIH website that has recently established links to many of the successful applications during the 2009 round of the C.T.S.A. process. At this site, one may also access C.T.S.A. writing team assignments as well as our UNC Translational Research Teams. These teams include: Program on Aging, Bowles Center for Alcohol Studies, Carolina Cardiovascular Biology Center, Carolina Center for Clinical Trials, Caviness General Clinical Research Center, Center for AIDS Research, Center for Gastrointestinal Biology and Disease, Center for Environmental Medicine, Asthma, and Lung Biology, Center for Infectious Diseases, Center for Maternal and Infant Health, Center for Women's Health Research, Clinical Center for the Study of Development and Learning, Cystic Fibrosis Pulmonary Treatment and Research Center, Lineberger Comprehensive Cancer Center, Neurodevelopmental Disorders Research Center, Neuroscience Center, North Carolina Area Health Education Centers (AHEC), and Thurston Arthritis Research Center. The C.T.S.A. site also provides resource information for investigators, including Research at Carolina, Animal Care and Use, Office of Clinical Trials, Office of Economic and Business Development, Office of Information and Communications, Federal Affairs, Grant Source Library, Office of Human Research Ethics (IRB), Odum Institute for Research in Social Science, Office of Postdoctoral Services, Office of Sponsored Research, Technology Development, and Office of Research Development.

Our newly formed Translational Clinical Science (TraCS) Institute offers pilot grants for fellows. Deadline for these 10k pilots is early December, with several rounds of funding per year. The general website is <http://www.tracs.unc.edu> (www.tracs.unc.edu/pilots.htm). Clinics offering expert resources for clinical and translational research are also available. The NC TraCS Institute offers daily and weekly clinics by appointment or walk-in where UNC-CH faculty members are available to consult across various NC TraCS services. The following clinics are available:

Biostatistics: Michael Hooker Atrium – Biostatistics faculty provide consultations on the design and analysis of clinical and translational science studies. M 10:30-12 noon; T 8:00-9:30 AM; W 1:00-2:30 PM; Th 1:30-3:00 PM; F 8:30-10:00 AM.

Grant Proposal Assistance: Old Clinic Room 4017. M 1:00-5:00 PM; T 9:00 AM – 1:00 PM. MacNider Room 122. F 9:00-10:00 AM.

Clinical and Translational Research Center – Meet with the Director, CTRC Conference Room, 3rd Floor Main Hospital, T 3:00-4:00 PM. Meet with CTRC Staff: Nursing, Bionutrition or Protocol Pipeline, M 3:00-5:00 PM, F 8:00-10:00 AM.

To make an appointment, contact NC TraCS by email nctracs@unc.edu or phone 6-6022.

IF YOU ARE INTERESTED IN GETTING A PAPER PUBLISHED IN A MAJOR JOURNAL, according to a senior editor of *Gastroenterology*, the following are some useful suggestions:

- Ask and unequivocally answer an important question
- Sub principles:
 1. State-of-the-art methods
 2. Statistical power statement and appropriate sample for selected design
 3. Conclusions based on data
 4. Concise discussion placing data in perspective: prior literature, pitfalls, future studies
- Clear abstract within word limits and compelling figures
- Read and understand “Instructions to Authors”

To Prepare:

- Write a compelling, non-declarative title
- Structured abstract
- Informative introduction, not a literature review – tantalize readers with a biologically plausible and engaging question
- Prepare graphs and tables first
- Conclusion – include future questions

Focus On:

- Mechanisms, diagnosis, and treatment of GI diseases

Additional Suggestions:

- It is very important to disclose conflicts of interest. If you received a grant for the study, you are required to do this.
- Reviewers ‘revise’, and editors ‘decide’.
- Clinical studies may reproduce results in a larger, different, or more relevant study group.
- See website for a checklist of questions asked about every clinical trial.
- Submit to a journal that is appropriate to priority, scope and breadth of your study.
- Volunteer to review and write editorials.
- Be mentioned by a senior faculty member.
- “Fast track review” is available to choose articles appropriate for *Clinical Gastroenterology and Hepatology* when submitted to *Gastroenterology* and denied (high acceptance rate).

For a research project, generally it takes three months for the collection of data, one month for the abstract, and two months for preparation of a manuscript, totaling six months prior to a presentation of the potential manuscript, with suggestions made for revision by a sophisticated audience. The NIH publishes an excellent Health Grant Writers' Workbook, http://www.grantcentral.com/workbook_nih_sf424.html (email orders@grantcentral.com).

It is important that all of us understand what constitutes plagiarism. For example, quoting yourself is plagiarism and can violate copyright restrictions. Follow this link to learn more:

<https://share.unc.edu/sites/som/dac/Documents/Plagiarism%20Presentation%20to%20DAC%207-5-2012.pdf>

If you are interested in presenting an abstract in poster form at a major conference such as Digestive Disease Week, fellows have found the site www.postersession.com to be most helpful. Nicolette deGroot, former Web designer for our division, has created her own web site showcasing her work at www.nicolettedegroot.com. Additionally, several fellows have had posters made for DDW at www.makesigns.com (www.graphicsland.com). A typical poster through MakeSigns can cost \$104.86 (\$53.99 for a 36" by 60" poster on glossy [recommended for posters]), \$14.95 for a 37" carrying tube, and \$35.92 for FedEx next business day shipping. A fellow can receive reimbursement for this as part of travel expenses related to conference leave.

Dr. Giardello from Johns Hopkins discusses tips for a successful poster presentation in this video: <http://www.youtube.com/watch?v=oLVbSakZlMA&feature=BFa&list=UL3p3NdNasX5w>

LITERATURE

Frequently needed numbers for **Health Sciences Library** (HSL), www.hsl.unc.edu (919-685-8122) include

- Information/Reference, www.hsl.unc.edu/asklib, 2-0800 (phone), 6-5592 (fax)
- Book Checkout/Fines, 2-0800
- Book Renewals, <http://web2.lib.unc.edu>, 2-0800
- Interlibrary Loan, 6-4998 (phone), 6-1537 (fax)
- Questions about Books and Journals, www.hsl.unc.edu/asklib, 2-0800
- Reserves, 2-0800
- UNCLEHELP, www.hsl.unc.edu/asklib, 2-0800

HSL now has journals available through BioMed Central and PubMed Central by going to the campus E-Journal Finder (search by individual title): www.eresources.lib.unc.edu/ejournal/. UNC is a member of BioMed Central, www.biomedcentral.com, an Open Access publisher. For more information, contact the Health Sciences Library at 6-0947.

A useful site for clinicians to bookmark is <http://www.hsl.unc.edu/Collections/clinicalref.cfm>. We have a clinical librarian specialist by the name of Karen Crowell, M.L.I.S. (kcrowell@email.unc.edu, 6-0951).

Because of financial constraints for 2009-2010, HSL has approved a reduction to the FY acquisitions budget by canceling more than 250 journal subscriptions after a comprehensive and systematic review of all journal subscriptions, including some GI-related journals. Potential cancellations can be viewed at <http://www.hsl.unc.edu/journalreview/index.cfm>.

The number for our Health Affairs Bookstore (formerly known as Caduceus) is 6-2208 (fax 2-2269), www.store.unc.edu/hab. Our HAB was formerly located behind Carrington Hall (School of Nursing); however, on 9/25/09 the store moved and is now part of the Student Stores located on main campus, directly across from the Bell Tower, and next to the Carolina Copy Center. The Ram Bookstore is located within UNC Student Stores, 969-8398, www.rambookstore.com.

An excellent site for an overview and in-depth information pertaining to all aspects of GI including endoscopic ultrasound in the evaluation of esophageal and rectal abnormalities, risk of pouchitis in ulcerative colitis, quality of life in IBD vs. IBS, intrahepatic cholangiocarcinoma, hereditary nonpolyposis, management of benign and malignant biliary strictures, incidence of obstetric cholestasis, gastric acidity: comparison of esomeprazole with other proton pump inhibitors, alternative therapies for chronic hepatitis C—to name a few—is <http://www.GastroHep.com>. This site will add over 130 full text review articles in 2004 and features cutting-edge abstracts and such journals as British Journal of Cancer, Acta Gastro-Enterologica, Annals of Internal Medicine, Journal of Hepatology, Journal of the American Medical Association, Current Opinion in Clinical Nutrition & Metabolic Care, Journal of Gastrointestinal Surgery in addition to free journal trials of Chinese Journal of Digestive Diseases, Colorectal Disease, Digestive Endoscopy, Diseases of the Esophagus, Helicobacter, Journal of Gastroenterology and Hepatology, Journal of Viral Hepatitis, Liver International, and Neurogastroenterological Motility. This site provides a comprehensive repository for GI-related reference and education, including—besides abstracts, journals, and review articles—slide atlas, drug information, advice for patients, case studies, dissertations, and endoscopy archives, with links to national GI societies and to international, USA and national, and commercial GastroHep links.

Sifting through the plethora of medical information can be daunting. JournalWATCH delivers it in a way that is efficient, concise, current and relevant, <http://www.JWatch.org>. This publication, with 50,000 physician subscribers, is made possible by the publishers of the *New England Journal of Medicine* and conveys a breadth of topics covered in the GI portion of JournalWATCH: JournalWATCH Gastroenterology.

The general medical journal web site, <http://bmj.bmjournals.com>, contains many listings of journals with articles relating to evidence-based medicine in different areas of medicine. One good article, “EBM: What It Is and What It Isn’t,” is found in Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. *BMJ* 1996; 312:71-72 (13 January) and defines EBM as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.” Another related article is “EBM: Does It Make a Difference? Use Wisely,” found in Druss Benjamin. *BMJ* 2005; 330:92.

Specifically, evidence-based issues in the management of patient care in gastroenterology can be found at www.evidence-based-gastro.com. At this site, you can also subscribe to receive the journal *Evidence-Based Gastroenterology*.

Another excellent source for articles relating to evidence-based medicine for improved patient care is the ACP Journal Club, published by the American College of Physicians. The journal can be found on ACP’s web site at www.acponline.org. Additionally, the *Annals of Internal Medicine* can also be found at this site; both journals can be found under the designation ‘Journals’. Internal Medicine’s premier educational meeting, its Annual Session for 2005, will be held in San Francisco from April 14-16. For more information, call 800-523-1546, ext. 2600, or 215-351-2600 (M-F 9-5 EST). One can register on the Web at www.acponline.org.

JournalReview.org is an educational venue recognized by the ACGME since 2005. As of July 2007, programs are required by the ACGME to have a curriculum that advances residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients and applied to patient care. JournalReview.org provides a form that facilitates discussion of any published article indexed in PubMed. Referring to JournalReview.org helps care providers to critically evaluate, interpret and appropriately apply current published literature to patient care. JournalReview.org contains authors and experts on every topic and in every field, thereby helping to create and stimulate educated and informative discourse.

JournalReview.org is an internet resource that facilitates open peer review and discussion of the medical literature, created solely by the dedicated work of two physicians, one medical student, and one computer programmer. Essentially an on-line journal club with free membership, JournalReview.org provides a venue whose ultimate aim is to improve communication and foster comment and criticism about published scientific research. If interested in gaining access to this service, contact Jeffrey Ellis, M.D., of JournalReview, LLC, email JEllis@JournalReview.org or info@JournalReview.org, fax # 319-937-1576, website <http://www.JournalReview.org>.

Those with an interest in basic science may enjoy subscribing to *Science*, www.sciencemag.or, and *Nature/Methods: Techniques for Life Scientists and Chemists*, www.nature.com/naturemethods. Dr. Thad Stappenbeck from Washington University has a lab web site at <http://www.pathology.wustl.edu/faculty/index.php?user=826&pageload=indi&passed=&sort=>. Over the last several years, Dr. Stappenbeck's lab has made important contributions to our mechanistic understanding of intestinal development, repair, and inflammation, as well as the roles of microorganisms and virus in these processes.

Google Scholar is a free service to glean scholarly citations, abstracts, and some full text from the web, <http://scholar.google.com>. Google Scholar enables one to search specifically for scholarly literature, including peer-reviewed papers, theses, books, preprints, abstracts and technical reports from all broad areas of research. Use Google Scholar to find articles from a wide variety of academic publishers, professional societies, preprint repositories and universities, in addition to scholarly articles available across the web.

Just as with Google Web Search, Google Scholar orders search results by how relevant they are to the query, such that the most useful references should appear at the top of the page. This ranking of relevance takes into account the full text of each article as well as the article's author(s), the publication in which the article appeared, and how often it has been cited in the literature. Google Scholar also automatically analyzes and extracts citations while presenting them as separate results, even if the documents they refer to are not online. This means that search results may include citations of older works and seminal articles appearing only in books or other offline publications.

Useful websites

American Association for the Study of Liver Diseases (AASLD), <http://www.aasld.org>,

Hepatology, Liver Transplantation

American College of Gastroenterology (ACG), <http://www.acg.gi.org>

American College of Physicians (ACP), <http://www.acponline.org>

American Gastroenterological Association (AGA), <http://www.gastro.org>,

301-654-2055 (phone), 301-654-5920 (fax), Gastroenterology, Clinical Gastroenterology

American Journal of Ethics, <http://virtualmentor.ama-assn.org>

American Journal of Medicine (AJM), www.amjmed.com

American Medical Association (AMA), <http://www.ama.org>, 312-464-5000 (phone)

American Society of Gastroenterological Endoscopy (ASGE), <http://www.asge.org>,
978-526-8330 (phone), 978-526-1703 (fax), [Endoscopy](#)

Annals of Internal Medicine, <http://www.annals.org>

Center for Teaching and Learning, <http://ctl.unc.edu>

Critical Appraisal and Evidence-Based Medicine,
http://www.cche.net/principles/content_all.asp

Crohn's and Colitis Foundation of America (CCFA), 1-800-932-2423

Department of Epidemiology, <http://www.sph.unc.edu/epid/>

Department of Medicine, <http://medicine.med.unc.edu>

Educational Technology Group, <http://www.med.unc.edu/etg>

JCAHO, <http://www.jointcommission.org>

Journal of the American Medical Association (JAMA), 312-464-2485

Learning Management System (LMS), <http://lmsweb.unch.unc.edu>

McLendon Labs, <http://labs.unchealthcare.org>

Medical Dictionary, <http://www.medterms.com/script/main/hp.asp>

New England Journal of Medicine, <http://www.nejm.org>

NIH, <http://grants.nih.gov/grants/guide/notice-files>

North Carolina Children's Hospital, <http://www.ncchildrenshospital.org>

North Carolina Consortium on Natural Medicines and Public Health, <http://naturalmedicinesofnc.org>

North Carolina Women's Hospital, <http://www.ncwomenshospital.org>

Occupational Health & Safety, <http://intranet.unchealthcare.org/hospitaldepartments/ohs>

Office of Clinical Trials, 3-2698, oct@unc.edu, Tammy Jayne, phone 3-2333, fax 2-3352, pager 216-4385.

Office of Educational Development, <http://www.med.unc.edu/oed>, 3-9369

Office of Research Integrity, <http://ori.dhhs.gov>

Office of Technology Development, <http://research.unc.edu/otd>

Physician Pages, <http://intranet.unchealthcare.org/physicians>
(Clinical Guidelines, CPOE, Medical Staff Bylaws and Forms, UNC Physicians' Newsletter)

Research Triangle Institute (RTI), <https://register.rti.org/internationalIRB/>

School of Medicine, <http://www.med.unc.edu>

School of Public Health, <http://www.sph.unc.edu>

Southern Medical Association, <http://www.sma.org>

UNC, <http://www.unc.edu>

UNC Children's Hospital Kohl's Online Health Resource Center
<http://ncchildrenshospital.staywellsolutionsonline.com>

UNC Copyright Law, <http://www.lib.unc.edu/copyright/>

UNC Health Care, <http://unchealthcare.org>

UNC Hospitals, <http://intranet.unchealthcare.org>

UNC Image, Display, Enhancement & Analysis (IDEA) Group, www.med.unc.edu/bric/ideagroup

UNC Statistics and Operations Research Department, <http://www.stat.unc.edu>

WebCIS, <http://webciss.unch.unc.edu>

SUBSPECIALTY RESIDENT AND FELLOW SERVICES

POLICY ON MAINTAINING CURRENT NCMB LICENSE

Yearly we must have a copy of each fellow's current NCMB license on file for auditing purposes.

Residents/Subspecialty Residents are **REQUIRED** to renew their licenses online at the NCMB website: www.ncmedboard.org. The menu options for annual license registration include a link for resident training licenses and a separate link for full licenses. Residents with a training license should choose "Annual Electronic RTL Registration" while those with a full license should choose "Annual Electronic Physician Registration." The Registration Fee is \$175.

Please note that, regardless of the Navy Portability Act, all physician fellows in the Navy cannot train in our program unless they obtain a NC medical license.

Please note that per the revised Policy on Medical License Requirements approved by the Graduate Medical Education Committee and the Medical Staff Executive Committee, effective July 1, 2006, if a resident's license is not registered by the date of birth then the resident will be removed from all clinical duties and could forfeit pro-rata stipend payments during the time his/her license has not been registered. (GME residents have been moved from UNC to hospital payroll.) This updated policy can be found on the Graduate Medical Education website at <http://gme.unchealthcare.org>.

If a resident's birthday falls on a Saturday or Sunday, s/he should register his/her license the Friday BEFORE the birthday by 4:00 p.m. so that the registration can be tracked. The Office of Graduate Medical Education will not be open over the weekend if a resident needs to find his/her File ID Number or License Number. When residents change their names, it is important that they also change their names with the NCMB. They can do this by visiting the NCMB website. To avoid such pitfalls, our GME Office has programmed the E-Value system to send out reminders.

CME CREDITS

In order for a physician to maintain his/her full NC license, s/he must present with at least 50 CME (Continuing Medical Education) hours per year as part of 1) his/her reappointment to the UNC Medical Staff and 2) yearly renewal of his/her medical license. The CME activity summary form must be completed by members of the Medical Staff (attendings and some fellows) because documentation of one's CME activities is a requirement for reappointment for clinical privileges. A physician must list all CME activities attended since his/her last appointment. Acceptable CME activities include attendance at Grand Rounds, GI Grand Rounds, department/division conferences/seminars, clubs (journal, endoscopy), specialty courses, and state/national meetings/conferences. For both Medicine and GI Grand Rounds, formal CME credit hours are assigned per successful completion of each session. Our UNC CME liaison, Doug Hudson, MLS, Assistant Director of our Office of Continuing Professional Development (office 919-972-7442, fax 493-8984), can provide a transcript of Medicine/GI Grand Round credits upon request, douglas_hudson@med.unc.edu. The web site <http://www.ncmedboard.org/cme.htm> contains a brief guide to CME requirements for physicians in the state of North Carolina. The American Board of Internal Medicine (ABIM) has a component as well for board certified physicians, its

'CPD' or 'Continuous Professional Development' program, which can allow one to maintain certification beyond the ten-year limit. The ABIM site is <http://www.abim.org>, phone 1-800-441-2246, fax 215-446-3590.

At UNC, yearly hours for Medicine Grand Rounds is one hour per week x 40 weeks = 40 hours, Clinical Case Conference (GI Grand Rounds) one hour per week x 45 weeks = 45 hours, GI Pathophysiology (Core Curriculum) Conference one hour per week x 40 weeks = 40 hours, and GI Journal Club two hours per month x ten months = 20 hours.

There is also a useful website, a kind of "CE compendium" containing CE requirements for hundreds of disciplines, called www.findCE.com, or one can email Kent Smith at educator@findce.com. Additional information about CME in general can be found at www.cmeinfo.com or, more specifically, www.GICME.com.

Additionally, residents who have completed three years or more of residency training are eligible for a free three-year endorsed Physician's Recognition Award (PRA) certificate from the American Medical Association (AMA). The PRA certificate recognizes and encourages physicians to participate in CME activities that meet AMA standards. Many organizations accept the PRA as a record of your CME, including 24 state medical boards. For more information, go to <http://www.ama-assn.org/go/prs>, or call 312-464-4672.

Through our CME Office, each year the Department of Medicine sponsors its Internal Medicine Conference. This year marks our 28th annual conference from March 31-April 2. To learn more about the conference, go to http://www.med.unc.edu/cme/im04_web.pdf. Faculty members representing all nine divisions of Medicine present talks on a variety of topics at the UNC Friday Center for Continuing Education. The purpose of this conference is to provide an update of the most useful recent developments in the diagnosis and management of specific medical disorders as primary care physicians and practicing specialists encounter them. Conference features include panel discussions organized to address questions and comments from participants about important issues in the practice of internal medicine, a program format inviting interaction between faculty and participants, minisymposia on topics of current interest, and an interdisciplinary approach to medical practice. This conference is designed for internists, family physicians, generalists, and other health care professionals working in an adult primary care setting. Subspecialty residents are encouraged to attend the GI portion of this conference free of charge by asking the fellowship coordinator to register them through the CME Office. Gastroenterology and Hepatology is usually the first segment to start the conference (this year, from 8:30-11:00 a.m. on March 31st) with presentations by Drs. Drossman, Fried, Isaacs and Shaheen.

Additionally, through our CME Office, in the past Dr. Shaheen (now assumed by Dr. Madanick) has arranged for a CME course given by faculty members of Gastroenterology and Hepatology. All subspecialty residents are encouraged to attend, again free of charge, not only to provide support for our faculty, but to enhance and broaden their clinical and therapeutic knowledge of the multi-organ system of GI. This year's course was held from April 1-3 and was entitled "Update in Gastroenterology and Hepatology: The ABC's of GI Disease," focusing on providing useful instruction to primary care providers; this course attracted more than 180 attendees.

Environmental Health & Safety

Ergonomics can be directed to Cindy Taylor at 6-0691 (fax 6-1973). An initial request can be completed at <http://survey.unch.unc.edu/TakeSurvey.asp?PageNumber=1&SurveyID=4108582375mLI>

and submitted to the Office of Ergonomics. A representative will visit your work area to evaluate it and make necessary adjustments based on recommendations.

Workplace safety issues can be directed to Thomas A. Smith, CHPA, CPP, Director of Hospital Police and Transportation: office phone 6-8116, email tasmith@unch.unc.edu. The OGME offers a workplace security survey at <https://survey.unch.unc.edu/TakeSurvey.aspx?SurveyID=16K0ml81>.

Flu Vaccine

We must make every effort to ensure that our resident physicians receive flu immunizations, for the following reasons:

- This is a matter of personal health and well-being for all working in a hospital environment.
- This is a protective measure to ensure the health and well-being of the resident's family.
- This is a professionalism issue: Immunizing health care workers protects our patients and thus represents a patient safety issue.
- As an incentive, there is a quality goal (set at 80%) for the UNC Health Care System: attaining it could mean a year-end bonus for the residents.

This responsibility should be taken seriously. The literature is clear that staff immunized against influenza have better inpatient outcomes.

Walk-in clinics are available at Occupational Health Services on the 1st floor, West Wing, of UNC Hospitals. You may contact Stephanie Consoli in OHS, sconsoli@unch.unc.edu, to schedule an appointment.

TB mask fit testing

All fellows are required to take TB mask fit testing on a yearly basis, as required by federal law. GME fellows paid through hospital Central Paymaster (including non-salaried fellows) are notified by the program coordinator as directed by OGME, and testing is arranged as a group.

For these fellows, prior to mask fit testing, the on-line self study for Respiratory Protection for Tuberculosis needs to be completed in LMS (Learning Management System) by going to <http://lmsweb.unch.unc.edu> within the UNC-H firewall or <https://lmsweb.unch.unc.edu> outside the UNC-H firewall. The user name is the fellow's EID (hospital ID number) or PID (campus ID number), with no dashes. The password is the last 6 digits of the EID or PID (unless this has been changed). Internet Explorer is required. Go to 'search', 'course catalog', and enter course code EHSFIT10.

For other fellows, prior to mask fit testing, the on-line self study for Respiratory Protection for Tuberculosis needs to be completed by going to http://www.ehs.unc.edu/training/self_study/resptb/sld001.htm.

In addition, all healthcare employees are required to take appropriate on-line training for safety in the workplace per our Department of Environment, Health and Safety (EHS) by going to <http://www.ehs.unc.edu/training/self.shtml>. Healthcare workers refer to the section labeled as "Clinic" and complete then complete that section. Any questions should be directed to Mary Crabtree, Workplace Safety Manager, at 2-5719.

UNC and Hospital Services

For fellows appointed to housestaff (hospital):

Benefits: Ginny Mays, vmays@unch.unc.edu, 3-0275 (fax 6-0290)
Office of Graduate Medical Education, 1st Floor Main Hospital
Occupational Health: Stephanie Consoli, sconsoli@unch.unc.edu, 6-4480 (fax 6-6326)
1st Floor West Wing
Parking: James Dean, jdean@unch.unc.edu, 6-1031 (fax 3-0111)
2nd Floor Neurosciences Hospital
Payroll: Ginny Mays, vmays@unch.unc.edu, 3-0275 (fax 6-0290)
Office of Graduate Medical Education, 1st Floor Main Hospital
*Residents salaried from clinical funds through Central Paymaster are paid biweekly.**
Photo ID Badge: James Dean, jdean@unch.unc.edu, 6-1031 (fax 3-0111)
2nd Floor Neurosciences Hospital

For fellows appointed to medical staff (UNC):

Benefits: Debbie Hamilton, Debbie.Hamilton@unchealthcare.org, 3-8609 (fax 6-4125)
325 Wing B Medical School
Occupational Health: Ann Law, alaw@unch.unc.edu, 6-9119 (fax 6-6337)
101 North Medical Drive
Parking: Lauren Paschal, lbp@med.unc.edu, 3-6350 (fax 6-5775)
121 MacNider
Payroll: Karen Clayton, karen_clayton@med.unc.edu, 3-6490 (fax 6-5775)
121 MacNider (Medicine) / Brandon Brooks, bsbrooks@email.unc.edu, 2-0048 (fax 2-5077)
Residents salaried from grant or industry funds are paid monthly.
Photo ID Badge: Quintel Henry, quintel_henry@med.unc.edu, 6-2441 (fax 6-2444)
41 MacNider – hours of operation: M & F 8:30 a.m. – 1:00 p.m.; W 2:00 p.m. – 4:30 p.m.

Non-salaried fellows through the military are appointed by the hospital.

*Residents paid through Central Paymaster should enroll online to receive paystubs. This allows easy access to paystubs, in addition to W-2 forms at the end of the year. The link to sign up is <https://advice.unch.unc.edu/auth/login>. When logging on, the EID (hospital employee number) field asks for 11 digits: adding zeros in front of your EID number is therefore necessary in order to make this work.

Residents paid through Central Paymaster have the option of signing up for Carolina FLEX benefits.

Effective 8/1/12, all residents paid through Central Paymaster must enroll in direct deposit by uploading forms through SharePoint or by bringing them in person to hospital payroll located at the James T. Hedrick Building (6-8070), off of 54 (Raleigh Road), in the same area as the Friday Center. As of 8/1/12, all checks from CP are to be direct deposited. Otherwise, residents must stop by the Hedrick Building to pick up their checks in person. Note that it takes at least one pay period (two weeks) for direct deposit to take effect.

Day Care and Other Services

A survey conducted last year by parents at UNC revealed that the issues pertaining to day care at Carolina are consistent with issues nationwide, namely: cost, quality and availability. 60% of

respondents had had some kind of child-care problem within the past year, either in finding care, affording care or finding care during the hours they needed it. 85% of respondents indicated that at some point they experienced a conflict between the need for child care and the need to go to school or work. Each year, 30 to 40 UNC families remain on a waiting list for referral and financial assistance in regard to day care services. The UNC parent population could be as many as \$1,500. Day care is an expensive commodity in Chapel Hill, one of the most expensive places to live in the state. Infant care in a four-star rated facility – among the best available – can cost \$1,100 a month. Some parents find centers for \$800 a month. Some work out options, such as finding in-home day care for \$600 a month three days a week, with the parents working out an alternating schedule.

Child Care Networks or Child Care Services Association (CCSA) (942-0184) serves as a resource and referral agency for child care, manages applications, and distributes financial aid to UNC parents in several Triangle counties, and a number of those parents are UNC students and staff. The CCSA distributes funding for UNC-affiliated parents provided by the University's Childcare Financial Assistance Program, which began in 1993. Each year, \$20,000 comes from the chancellor's discretionary fund to support this service. From a budget of \$120,000, the Chancellor's Childcare Advisory Committee, which was established in 1988 by Chancellor Paul Hardin to gather information and provide advice regarding child-care issues on campus, distributes \$65,000 per year in scholarships, with three-quarters of that money reserved for employees, and the rest for students. Last fall, UNC enacted a student referendum to add 75 cents in student fees to support student-parents with scholarships and financial aid for child care. That fee is expected to generate \$50,000 in money for student-parents. This means that currently the CCSA's budget has jumped from \$51,112 to \$171, 112. The CCSA can provide a list of quality child-care providers in the area, information on child-care rules and quality, health insurance, tax credits and financial assistance options.

Two campus day care centers include Frank Porter Graham (6-2622) and Victory Village (929-2662). The Frank Porter Graham Child and Family Center opened in 1966. Victory Village Day Care Center opened in 1998 and is located on 130 Friday Center Drive at the Friday Continuing Education Center complex. In 1952, a group of parents, mostly graduate students, organized a child-care co-operative. Victory Village, as it was called, was operated as a student organization, funded in part by student fees. Located near Odum Village (student family housing) across from UNC-Hospitals, Victory Village served close to 60 families of students, faculty and staff. Its reputation for quality care led officials at UNC-Hospitals and UNC to examine Victory Village as they began planning to combine resources for a larger child-care center to serve the hospital and university students, faculty and staff. This resulted in a joint campus-hospital venture: a new \$1.9 million 10,500-square-foot state-of-the-art child-care center on the Bill and Ida Friday Continuing Education Center campus. Costs start at \$725 a month, with a month of infant care costing \$1,050. This compares to an in-state undergraduate's tuition of \$4,072 a year; such child-care costs rarely are affordable unless the individual is married to a spouse with a well-paying job; most of the children at Victory Village are those of faculty and staff. Recently this year, Victory Village became The University Child Care Center and has been established to provide child care for employees of UNC Health Care and the University and for UNC-CH students whose children fall between six weeks and five years of age. For information about this program and/or to tour the Center, please contact The University Child Care Center, 130 Friday Center Drive, Chapel Hill, NC 27517, phone 9-2662, fax 9-2632; email victoryvillage@mindspring.com, website <http://victoryvillage.home.mindspring.com>. UNC also has an office of child-care/work-family, 2-1483.

Additionally, Helping Heels Care Provider list is available on the Human Resources web site at <http://hr.unc.edu/Data/benefits/workfamily/childcare/providerlist/index>. This list includes UNC-Chapel Hill affiliated individuals who are interested in providing part-time and occasional

child and elder care. The responsibility for the screening process rests solely and completely with caregivers and the person hiring them. Although skill information is submitted on the provider registration form, providers may not necessarily be trained to care for persons with medical or psychiatric conditions requiring specialized care. The Helping Heels Provider List includes detailed information about providers, including UNC affiliation, provider experience, availability and access to transportation so that you can make a more informed choice about whom to call. The list is searchable by clicking on the ‘Search’ (binoculars) button in Adobe Acrobat. Provider availability may shift during the course of a semester, and the Helping Heels Care Provider List will be updated for the summer months. The summer list should be available in late May. If you have any questions about this service, please contact Aimee Krans, Work-Life Manager, at 2-6008 or aimee_krans@unc.edu.

UNC employees with children in grades K-5 have a convenient option for afterschool care on campus. The Morehead Afterschool Program (MAP) at Morehead Planetarium and Science Center offers science activities, indoor and outdoor play, snacks, and crafts. Children from Carrboro, Ephesus Church Road, Frank Porter Graham and McDougle elementary schools travel from school to Morehead via Chapel Hill transit, escorted by MAP staff members. Check out the MAP web site at www.moreheadplanetarium.org/go/afterschool for more information and for online registration access. Please contact Jonathan Frederick at 3-7951 with any questions.

Spanish for Fun Academy is located right near our ACC/Mason Farm Road on 1001 South Columbia Street (across from Coolidge Street), phone 969-9055, www.spanishforfunacademy.com.

Montessori Academy is located on 1200 Mason Farm Road, 272-8554.

Chapel Hill Community Church (located directly behind Bioinformatics Building off of Purefoy Road) offers day care service as well as parking opportunities. Please contact Andrea Sordean-Mintzer at 942-2050 ext. 5 (email finance@c3huu.org) to sign your child up for day care or to apply for a parking space.

Chapel Hill Kehillah (located directly behind Bioinformatics Building off of Mason Farm Road at the corner of Purefoy Road, diagonal to CHCC) also offers day care services as well as parking opportunities. Please contact Stephanie Stuchiner at 942-8914 (email admin@chkehillah.org) to sign your child up for day care or to apply for a parking space.

For breastfeeding support options at UNC, please contact Amoreena Ranck Howell, MD, MSPH of our Department of Family Medicine at achowell@email.unc.edu.

Pet Services

Creature Comforts Inn and Animal Hospital, 200 West Cornwallis Road, Durham, NC 27707-2934, 489-1490, American Boarding Kennel Association Member, www.creaturecomforts.com.

‘All about Pets’: Anna’s Pet & Housesitting Service: (919) 306-6447.

Kate’s Kritter Kare & Kleaning: pet sitting/cleaning/gardening/odd jobs in SW Durham and vicinity – Kate Turlington (919-943-8083), Kate_Turlington@yahoo.com; exceptional service, competitive rates, outstanding references.

Food Services

Given our center's acute and tertiary care status, the choice of food service in our medical complex is slim. Gastroenterology subspecialty residents are provided a one-time yearly payment of \$120 for meals through the Freedom Pay service (1-888-495-0222, www.FreedomPay.com). Freedom Pay is a turnkey cashless solution that allows food service providers to offer their customers the convenience of paying without cash. UNC participates in this program, and individuals issued cards can use them at any of the food service areas where a Freedom Pay card machine is displayed.

The cafeteria in the upper floor of the Children's Hospital has undergone extensive renovation and is now open for breakfast, lunch and dinner. Called 'The Terrace', many individuals have commented on the gourmet style food at reasonable prices. On the Ground Floor of the Main Hospital in the connector between it and the Children's Hospital, there is a snack bar called the 'Corner Café'. Feedback has been very positive in regard to the food served here. The 'Overlook Café' is a rather upscale snack shop serving paninis and pizza on the 2nd floor of Neurosciences. 'Beaches Café' is a large snack area located directly under our TraCS Center behind the Old Clinic Building, adjacent to MacNider, Bondurant, and Berryill Halls. The 'Little Beach Café' is a small snack bar open from 8:30 a.m. - 3:00 p.m. on the first floor of MacNider Hall. The Tar Heel Café, located in the back of Thurston-Bowles Building, is open for breakfast and lunch and contains a deli and Chick Filet. There is a snack shop open in the a.m. and for lunch next to the ACC Building that serves snacks and hot dogs. Coffee can be bought at Friends' Café in Health Sciences Library, at Starbuck's on the ground floor of the Cancer Hospital, at the Tar Heel Café in Thurston-Bowles, and at the Kind Café in the lobby of Bioinformatics.

The overpass floor of the Cardinal (Employee) Parking Deck has one soda machine to the left as you enter it from the hospital and a soda machine with Gatorade to the right as you leave it across from Bioinformatics. On the ground floor of Bioinformatics outside of the Mail Center there is a soda machine and a candy machine. Soda and snack machines are also located on the ground floor of the Old Infirmary Building at the side entrance, on the ground floor of MBRB, on the ground floor of the Dental School, and outside the Dental School in the patio area. A list of local restaurants can be found at <http://gcrc.med.unc.edu/staffres/lunch.htm>.

Wellness

Residents can visit <http://gme.unchealthcare.org> under 'residency links' to view our GME policies regarding stress management, impaired physicians and performance problems, counseling services, and the handling of academics. Each year, the fellowship coordinator has fellows review our resident LIFE curriculum (www.lifecurriculum.info), a learning program developed to address resident impairment and fatigue to enhance patient safety, quality of care, and resident well being. Located on our shared J drive, included with information on our fellowship program serving as orientation and ongoing resource materials for our fellows is a section on housestaff policies, which includes fit-for-duty policy, as well as a disaster recovery plan.

GME has created a hotline registering concerns confidentially: 919-966-1772. Mental health specialists at UNC can be reached at 9-7449 (fax 9-0536).

Physicians may also want to attend a seminar given by the Physicians Wellness and Weight Loss Program by contacting Bob Wagner at 1-800-234-9283 (fax 1-866-825-5216).

Women are encouraged to join our local Triangle Rho Tau chapter of Graduate Women in Science (GWIS) by emailing Rho Tau GWIS at rhotaugwis@gmail.com.

Medical Auxiliary of UNC-Hospitals

The Medical Auxiliary of UNC-Hospitals is a non-profit social and philanthropic organization formed by and comprised of female housestaff as well as spouses and significant others of medical students, residents, fellows and attendings at UNC-Hospitals. Its purpose is to promote fellowship among members through enjoyable and interesting activities, programs, and projects. In addition, members strive to combine efforts to make a difference within UNC-Hospitals and the community. Current philanthropic endeavors include purchasing parent education materials for the neonatal intensive care unit, annual holiday bazaar benefiting the Children's Hospital, and collection and donation of children's books for the UNC Pediatric Clinic's 'Reach Out and Read' program. If you or your spouse is interested in membership, please contact Erika Hubbard at 919-361-5195 or email her at ehubbard@nc.rr.com.

The Triangle Medical Spouse Alliance is a social and service group comprised of spouses and significant others of UNC and Duke residents and fellows. If you are interested in joining their group, please visit their site at <http://trianglemdspouses.blogspot.com> or email them at trianglemdspouses@yahoo.com.

Gastroenterology and Hepatology Fellows' Leave Policy

Vacation

Fellows are allotted 15 days (three weeks of five workdays each) for vacation per year, not to include conferences, two days in August for the taking of boards, or hospital holidays. Vacation time may be taken during research blocks and endoscopy blocks. In general it cannot be taken on consults, hepatology or clinic blocks. If you have plans that fall during this block of time you will need to have approval of the attending for that block and have someone who is uncommitted during that block cover your work. For clinic time that lands during vacation you will need to let the program director and the GI clinic scheduler know so that your clinic may be blocked for that day. Any vacation time beyond the allotted 15 days must be approved by the Division Chief and may be subject to being classified as unpaid leave. You will need to let the fellowship coordinator and the clinic nurse know about your vacation days so that they can be recorded and patient calls can be dealt with. Please leave a message on your pager, your email and your phone mail to notify those trying to contact you that you are out. If you are a research fellow but have a continuity clinic, please let the coordinator know of your absence in this respect. Otherwise, research fellows report absences to those who oversee their training grants (Dr. Sandler for epidemiology and Dr. Sartor for basic science). A specialty fellow reports absences to his or her immediate supervisor or mentor. Leave time does not carry over from year to year and must be taken yearly. A fellow is not to use his or her last three weeks of training with us as vacation time and is expected to be here until June 30th. Fellows are permitted to be absent for required jury duty.

Conference Time

Each fellow will be allotted five days per year for conference time, two of which may fall during clinic time. Clinic time taken for conference leave beyond the two days must be made up. This includes time missed for AASLD, DDW, conferences held for fellows, etc. Any days taken off for conference beyond this time will need to be approved by the Division Chief and may be subject to being classified as unpaid leave. First-year fellows will be covered for the AASLD meeting, and second-year fellows will be covered for DDW. For all other conference time, fellows must arrange to have their scheduled duties covered by another fellow and must let the attending physician for that clinical block be aware of the conference coverage.

Interviewing/Job Search Time

Each fellow during their fellowship will be allotted five days for interviewing/making job arrangements etc. Any additional interviewing or job-related activities must be taken as vacation days. Any days required beyond the allotted time must be approved by the Division Chief and may be classified as unpaid leave. Make sure that you leave enough time to do this, or you may find yourself short paid days off at the end of the year.

FAMILY AND MEDICAL LEAVE

All duly appointed members of our Housestaff and Medical Staff (both subspecialty residents and fellows) who are working at least 20 hours each week are entitled to a total of 12 weeks leave during any 12-month period for one or more of the reasons listed below. A maximum of six of the 12 weeks may be paid leave as long as the resident or fellow has exhausted his/her vacation leave as part of the paid six weeks and the Division Chief has approved that this leave be paid.

Reasons for Leave

The following are all justifications for taking Family and Medical Leave:

- for the birth of a child and to care for the child after birth, provided that leave is taken within a 12-month period following birth;
- for the resident or fellow to care for a child placed within his/her residence for adoption or foster care, provided that leave is taken within a 12-month period following adoption;
- for the resident or fellow to care for his or her child/spouse/parent where that child/spouse/parent has a serious health condition; or
- the resident or fellow has a serious health condition that makes him or her unable to perform the essential functions of his or her position.

In the past, both maternal and paternal leave has been approved for fellows, and in one instance during the prolonged illness of a fellow's child. In this case, from a training or educational standpoint, it is up to the program director's discretion and judgment—both in terms of clinical and procedural competence—if a subspecialty resident must be absent for a prolonged period of time, to decide whether or not that resident is at a level where s/he can complete the program as scheduled or if s/he needs additional time to complete our program.

If a subspecialty resident or fellow would like to read the UNC Policy on the Family and Medical Leave Act (FMLA) in its entirety, s/he may obtain a copy that the fellowship coordinator keeps on file, in addition to the Act as found in our 'GI Fellows' folder on the shared J drive.

MAIL SERVICES

In 4100 Bioinformatics, the administrative offices for Gastroenterology, in the center of our complex is our mailroom where employees can place unstamped (mail to be metered), stamped US mail, or campus mail in the appropriate trays. The UNC mail center for our entire campus is now located on the ground floor of Bioinformatics. Please remember that all outgoing mail – including campus mail – must be routed first through this central office. Hence, sending something through our mail system may cause a delay of one or two days.

We have a part-time employee who distributes our incoming mail. Our mail room in 4100 Bioinformatics contains individual mailboxes for all of those individuals occupying that floor. The GI Division and our Program in Digestive Health occupy the greater part of that floor, with pulmonary and neurophysiology occupying a smaller portion. As a division, GI is larger than many departments, and we are physically spread out. Fourth floor Bioinformatics houses GI administration, Program in Digestive Health (PDH, formerly CGIBD), our Functional Bowel Disease Center, and our Esophageal Center. The GI Division's campus box (CB) number is 7080; PDH's CB number is 7555. The entire seventh floor of the Biomolecular (MBRB) Building occupies our labs, including the IBD labs for Drs. Jobin, Plevy, and Sartor; the liver lab for Dr. Hines; the esophageal lab for Dr. Orlando; the cancer genetic lab for Dr. Keku, and the stem cell labs of Drs. Henning and Magness. The CB number for this area in MBRB is 7032. Our Liver Program is located on the eighth floor of Burnett-Womack Building, CB# 7584. Our Clinical Trials Unit, located on the ground floor of Burnett-Womack Building, has a CB number, 7209. We still have a small lab in the Glaxo Building, CB# 7194. Our GI medicine clinic is located on the first floor of the main hospital, and our GI procedure unit – along with the clinical fellows' space – is located in the basement of the main hospital. The hospital's campus number is 7600. Our endoscopy suite at Meadowmont is considered part of the hospital – although off site – and so the campus number for Meadowmont is also 7600. Anytime mail is to go to the hospital, the appropriate area should be designated: GI Medicine Clinic, First Floor Main Hospital, CB# 7600; GI Procedures Unit, Basement Main Hospital, CB# 7600; Endoscopy Center, Meadowmont, CB# 7600.

Along with individual mailboxes in our mail room in 4100 Bioinformatics are separate mailboxes for Drs. Bozyski, Grimm, Isaacs and Scarlett in Procedures and for Procedures itself, as well as for the clinical fellows in their space. This mail is brought over daily. All other mail is forwarded on to their respective Centers by that Center's CB#. Epidemiology research fellows occupy space on the fourth floor of Bioinformatics and therefore have individual mailboxes. Mail for fellows doing basic science work on the seventh floor of MBRB is forwarded to them to CB# 7032.

Procedure letters the fellows wish to be sent out can be placed out front in the unit reception area where they will be picked up and taken to the hospital mail room or in the fellowship coordinator's tray in their space, where the coordinator can pick them up and take them to the hospital mail room. The hospital mail room is located on the first floor of the Old Infirmary Building, the wing that connects with the Old Clinic Building. In addition to the hospital mail room, this wing houses hospital telecommunications and our Office of Graduate Medical Education (OGME).

Fellows who wish to send out mail can use the hospital code 2604 in the upper right-hand corner of the envelope so that the hospital covers this charge, but only for hospital-related mail. In the past, this has been a problem, and at one point hospital officials checked mail, only to find many were not patient-related at all. For HIPAA purposes, it is best that you seal correspondence containing sensitive patient-related information.

Residents already at UNC moving into our subspecialty residency program used to have the option of keeping their resident mailboxes on the ground floor of the Old Infirmary Wing across from the Office of Graduate Medical Education; however, this has been discontinued, since mail is delivered daily to the clinical fellows in their space in B027 in the basement of the main hospital. Each fellow sharing that space has a mail slot on the wall. The fellowship coordinator has a tray in this space where the fellows can put material for his attention, including items they would like for him to mail out. Often he puts items for the fellows directly on their desk—if it is something they need to be aware of and not overlook, he emails them. Fellows are asked to clear out their mail trays on a daily basis and to separate junk mail from important mail, discard the junk mail accordingly, and address

the important mail in a timely manner. They are asked not to keep their area messy with papers scattered on the floor or spilling over the trays, especially if this information is patient related. Such information should be dealt with as soon as possible and then disposed of properly or filed away in a secure place.

Mail can be sent certified from the hospital mailroom; if this needs to be done, the fellowship coordinator can do this.

In 1/2003 the GI administrative offices moved from the seventh floor of Burnett-Womack to the ground floor of Bioinformatics, and in 1/2005 we moved again, from the ground floor of Bioinformatics up to the fourth floor. Anytime you need a business address for your program, please use

Gastroenterology & Hepatology
4119B Bioinformatics Building
130 Mason Farm Road
University of North Carolina
Chapel Hill, NC 27599-7080
phone 919-966-2514, fax 919-966-6842

At each new academic cycle, the fellowship coordinator distributes a comprehensive GI division list of our employees and their contact information to the incoming subspecialty residents.

The fellowship coordinator can also Fedex any manuscript articles or other documents. Our Fedex account number is 1847-8372-0. There are Fedex drop-off boxes on the fourth floor of Bioinformatics by the door of 4100, on the loading dock outside of Bioinformatics in the back, and outside of the Dental School. The last pick up of the day for items dropped off is 7:00 p.m. Fedex's web site, for checking the status of articles in transit, is www.fedex.com, 1-800-238-5355. Also at the Dental School are boxes for DHL (last pick up 5:30 p.m.) and UPS (last pick up 7:00 p.m.).

If a fellow has published a journal article for which s/he gets national/international requests, the fellowship coordinator can keep a PDF file of this article, print it out, and send it to the requesting individual or entity.

Photocopy Services and UNC One Card

Upon request and based on the availability of funds, fellows may be issued a UNC Departmental Copy Card for research purposes with an initial amount of \$50. If this amount is used up, \$50 more can be added to the existing card. Photocopying for Journal Club is no longer necessary because articles are posted online. Copy Centers are located throughout campus, notably, for fellows, at our Health Sciences Library. Fellows are also provided a USB memory chip to carry with them to use for presentations.

A fellow may purchase a UNC One Card by going to the UNC One Card Office (2-1385) on campus, located below the new Student Center. In order to purchase a One card, you first need to provide your PID (employee) ID number, which should be in their computer system. A UNC One Card allows you access to the campus gym at a reduced rate. For those appointed to the Medical Staff, a UNC One Card is required for parking.

Otherwise, the fellowship coordinator has made copies for the fellows if they need them. The fellows can put what needs to be copied in the coordinator's tray in their space. In Bioinformatics, a

copy machine is located in the mail room of 4100, in the area of our GI administrative offices. The copy code number for this is 1888. This is the code designated for the fellowship coordinator and fellows. This copier is now tied into a campus-wide system, and therefore our department number must now precede the code number: 4228. A smaller copier is also located in this same space, used by members of our Program in Digestive Health. The general code number is 1111, and the department number is 4283. Of note, Carolina Copy has had to make several visits for repair of serious paper jams for this copier. This type of jam is caused by copying books with the lid up: the fuser cannot handle pages with large amounts of black space, and this is what causes the jams. The copier will automatically subdivide a book into two sheets, and then increase the size of the pages to fit an 8.5 x 11 sheet so that the black space is eliminated. For copier repair, Carolina Copy's number is 2-2539, reference copier U10709. Other photocopiers include one in our Liver Program (code 6660) and one in the GI Procedures Unit (code 77777).

For bulk copies, we use the Copy Center below the Student Union on main campus, phone 3-6862 or 3-6863, fax 3-6861. This Copy Center also offers free courier service by calling 2-6571 or 2-6572.

Our CGIBD unit has a scanner located in the student area of 4128A Bioinformatics (6-8767). Paris Heidt has a scanner in 4162N Bioinformatics (6-0764). Our Functional Bowel Group also has a scanner (contact Kirsten Nyrop at 6-0146).

Disposal of Papers

In the fellows' space in B027, there are two bins, one for regular paper, and a Shred-It bin, for patient-sensitive information (bin # 1936). Please make sure that all confidential papers go into the Shred-It bin. One mini Shred-It bin has been placed each in manometry room 1 and manometry room 2. These are not indicated by number. A request has been submitted for these to be identified. There is a Shred-It bin in the open area of Procedures (bin # 1937) and in the reception/check-in area (bin # 1166). There needs to be additional bins in the unit, and so a request has been made for mini bins to be placed in the recovery unit and in the doctor's work room (B016 – room 4).

The Shred-It bin people are supposed to empty hospital bins on a weekly basis due to the high volume of paperwork generated within hospital space. In other locations outside of the hospital setting, such as Bioinformatics, for example, the Shred-It people empty once monthly, generally on a Friday or Monday. To maximize security, the Shred-It people shred and dispose of confidential documents right on campus. For Bioinformatics, this is done at our loading dock. Shred-It bins are also located in the GI Medicine Clinic corridor to the left of Exam Room 4 (bin # 1005), one in the physician workroom (bin # 2236), and one shared with GI Surgery, bin # 1460. There are four Shred-It bins in our Liver Program on the eighth floor of Burnett-Womack: two located in the corridor to the right (bins # 5402 and 5405), and two in the corridor to the left (bins # 5403 and 5404). One bin is also located on the ground floor of Burnett-Womack in our Clinical Trials Unit (room 1042), bin # 5407. There is one bin located in MBRB, outside the administrative offices of our Inflammatory Bowel Disease (IBD) Center, bin # 1800.

On fourth floor Bioinformatics, Shred-It bins are located between rooms 4144 – 4145 (bin # 3265), next to the elevator beside our mail room (4182), bin # 3264, across from room 4154, bin # 3363, at the entrance to 4100, bin # 2611, beside our mail room (4182), bin # 3266, and two in our kitchen (4128), bins # 1073 and 2312.

Fellows are asked to keep their area clear of strewn confidential materials and to process and file for safekeeping or disposal as quickly as possible. This is of particular concern around their fax machine.

Contact information for Shred-It is Tim Hackman at 919-423-0630 or Brandy at 1-800-717-4733.

For recycling, in hospital space the number is 6-5611; for UNC space it is 2-1442 phone and 2-8794 fax.

Fellows' Space

For clinical fellows located in hospital space in B027, keys are issued by the nurse supervisor for GI Procedures. Fellows have been asked to lock the door to their space after 5:00 p.m. daily because in the past some valuable textbooks have come up missing and never returned. This space ideally holds six fellows, seven at the most. When clinical fellows leave, those who remain repartition the area for themselves, leaving more or less whatever space to take for incoming clinical fellows. For a basic science research fellow located in 7317 Biomolecular, s/he needs to see Lisa Holt, lab manager, about keys, sarahbea@med.unc.edu, 6-7886. For epidemiology fellows located in the Bioinformatics Building or basic science ones in the Biomolecular Building, s/he will have to have a building access card because these buildings lock automatically at 6:00 p.m. and reopen at 6:00 a.m. daily. For this, the fellow needs to see Shelly Fritts, our division assistant administrator, shelly_fritts@med.unc.edu, 6-0775, or the fellowship program coordinator.

For surplus of items located in hospital space, the fellow should contact the nurse supervisor. The hospital surplus contact person is Tim Allen (6-1534, tgallen@unch.unc.edu), supervisor Luis Soto at 6-1139. If the item to be surplus has a UNC-Hospital tag number, a surplus form must be filled out at <http://www.unch.unc.edu/SurplusFormFD.pdf>. If there is no UNC-Hospital tag with the item, email Tim Allen per above, with an indication of what is to be surplus and from what location, along with your name and phone or pager number.

If an item needs to be surplus from UNC space, the fellow should contact Dale Schneider (dale_schneider@med.unc.edu, 3-3649). For all computer items to be surplus, per HIPAA regulations, we must have the hard drives sanitized. This can be done by notifying Steve Kennedy, our HIPAA coordinator, in conjunction with Tim Allen, IT specialist, 3-8526, trallen@med.unc.edu.

For repairs in the fellows' space, the number for hospital maintenance (plant engineering) is 6-4484. For repairs in UNC space, contact UNC Facility Services at 2-3456 and reference our working order number 4228 040.

In the fellows' space in room B027, if toner needs to be ordered for their fax machine or copier, Dale Schneider per above can order this. The fax machine uses a Brother DR-400 drum and a Brother TN-460 toner cartridge; the 4100N copier uses a C8061A toner cartridge.

The fellowship coordinator is located in 4119B Bioinformatics Building, Steve Kennedy, skennedy@med.unc.edu, phone 6-2514, fax 6-6842. Dr. Madanick's office is located in 4142 Bioinformatics, madanick@med.unc.edu, phone 3-6686, fax 3-2508, pager 216-2492.

PREFIXES TO INTERNAL PHONE NUMBERS: For in-house and intercampus calls, we use the prefixes 2, 3, and 6 plus the four-digit number, the prefixes representing 962, 843, and 966, respectively. The actual phone numbers of the fellows' space is 6-1754 and 6-1756, with the fax number 3-3521. Otherwise, a research fellow in Biomolecular has the number 6-7886 (fax 3-6899). The fax number for GI administration in Bioinformatics is 6-6842; the fax number for the Liver Program is 6-1700. Fellows with assigned areas in Bioinformatics may or may not be issued their own phone number, depending on availability of funding.

Supplies

If a fellow needs any supplies, such as hanging folders, etc., s/he may notify Tiffany Eubanks at 3-1072, tiffany_eubanks@med.unc.edu, who orders our supplies from Staples. Dr. Eric Orman is the contact person in this regard for the fellows' workroom in the basement of the main hospital.

Supplies may be ordered on line on our website

<https://cgibd.med.unc.edu/coreuse/purchasingreq.php> (use Internet Explorer 8, preferably FireFox). This site contains five forms:

- request for services
- new PI proposal
- maintenance request
- purchasing request
- lab coat orders

Questions can be addressed by calling 3-3946 or emailing cgibdweb@med.unc.edu.

Business Cards

The fellowship coordinator orders business cards for each fellow, usually at 250 per order. Per consensus of the fellows, each card contains our logo, plus the fellow's name and title, address, phone number, fax number, clinic appointments number, endoscopy appointments number, and clinic Rx number. No email addresses are to be displayed on the business cards. If a fellow wishes to include his email address for patient correspondence, s/he must notify Steve Kennedy, the HIPAA coordinator. It is important that, while on any clinical service, you check your voice mail on a twice daily basis to retrieve any patient-related calls. The clinic nurse will triage all prescription refill and other related calls coming in to the clinic Rx number to the appropriate fellow.

The information posted on a business card can vary, depending on if a fellow is doing a research year or an active clinical one. Business cards are modified to reflect the fellow's current position. If his or her status changes, the coordinator needs to know so that new business cards can be drawn up. Generally, a clinical fellow's business card contains this information:

Jonathan J. Hansen, M.D., Ph.D.
Fellow
Division of Gastroenterology and Hepatology
Campus Box 7080
Chapel Hill, NC 27599-7080

with the UNC School of Medicine logo to the left, followed by, under the information above

Phone: 919-843-2638

Fax: 919-843-3521

After hours, call 919-966-4131 and ask for the GI physician on call

As of 9/20/12, per Dr. Spencer Dorn, Director of our GI Medicine Clinic, all fellows are to have professional email addresses listed on their business cards for better patient communication.

FELLOWS AND MOONLIGHTING

Subspecialty residents and fellows, like attendings, *as long as they are clinically active*, are covered by UNC Liability Insurance Trust Fund offered through Medicine through UNC P & A.

UNC fellows and attendings are covered while carrying out clinical duties **anywhere within the physical parameter of UNC (hospital-campus)**. This would include ‘moonlighting’ in areas such as Emergency Medicine. In the past, many of our fellows have moonlighted at UNC Urgent Care. However, with the discontinuation of this clinic, Dr. Pamela Clanton directs our Hospitalist program, where fellows can moonlight as an alternative. Contact information includes Carolyn F. Crank of General-Internal Medicine, phone 6-2276 (ext. 269), fax 6-2274. Fellows interested in moonlighting in EM are asked to contact the program director, Dr. Judith E. Tintinalli, at 3-3045 or judith_tintinalli@med.unc.edu.

If we have contracted services with another institution, such as Wake and Fayetteville VA for our attendings, they are covered by UNC. Additionally, fellows are covered for any contracted services constituting part of or an extension of their current training program with us. However, if a fellow chooses to moonlight in an area outside of UNC and one for which we do not contract educational services (s/he wants to earn extra money to provide services elsewhere not required by us), such as at Central Prison or in a private practice, **the fellow must make sure that s/he is covered by this facility**. In the case of Central Prison and private practices, generally they provide liability insurance coverage for an outside physician who works for them. This applies to attendings as well. Most attendings and fellows do not feel the need, therefore, to carry personal insurance in this respect since they are covered by UNC.

When a fellow moonlights in a non-UNC, non-contracted venue, it is thus very important that s/he is covered either by the outside agency or individually because if a malpractice suit ever arose, it would be between the litigant and the agency providing the liability coverage.

Our Office of Graduate Medical Education (OGME) asks that the fellowship coordinator provide documentation of each fellow’s “acknowledgement of moonlighting activities.” This includes a ‘description of activity’ and ‘site of activity’ with the following requirements met for moonlighting at UNC:

- The fellow has a permanent (full) NC medical license. This license **must** be renewed yearly on the fellow’s birthday with no lapse at a cost of \$175 per year. The NC Board of Medical Examiners address is 1203 Front Street, Raleigh, NC 27609 or POB 26808, Raleigh, NC 27611; phone 919-326-1100 or 800-253-9653; fax 919-326-1130 or 919-326-1131; email info@ncmedboard.org, web site www.docboard.org/nc. The ‘certificate of registration’ refers to the NCMB license, of which there is also a smaller wallet size. The site for renewal of licensure is www.ncmedboard.org/seal.htm. Due to a large volume of forms to process, the Board cites email as the preferred method of correspondence. *A copy of the fellow’s current NCMB license must accompany the GME moonlighting request form. In addition, as of 7-12-12, GME requires that you attach a copy of your personal DEA certificate or, if you do not have your own, attestation from the institution stating that you are allowed to use their DEA number.*
- The fellow has adequate liability coverage. (This means not only UNC but any other outside source of liability coverage, which the fellowship coordinator must verify with the fellow and/or outside source.) *Confirmation of current liability coverage must accompany the GME moonlighting request form for non-UNC agencies. This confirmation must be from the risk management office. GME also requires that a copy of your employee work agreement be included.*

- The fellow has appropriate training skills to carry out assigned duties. (The skills for which s/he is credentialed for clinical privileges and comparable background experience in training relate to and are commensurate with the duties required for moonlighting.) For our fellows who are BE/BC in internal medicine, this would involve medical evaluations of admitted patients. A comparable description must be indicated on the moonlighting request form.
- The total hours worked, including moonlighting, do not exceed RRC (Residency Review Commission) requirements. (The moonlighting hours must not interfere with a fellow's training with us and his/her optimal performance, also dependent on his/her schedule with us such as endoscopic rotation, etc.) Thus, fellows must include average # of hours per week moonlighting, in addition to average # of regular program hours per week.

The moonlighting form must be completed by the fellow, signed by the Program Director (Ryan D. Madanick, M.D.), signed by the Chair of the Department of Medicine (Marschall S. Runge, M.D., Ph.D.), submitted to the OGME, and approved by the GME Executive Committee at its mid-monthly meeting before the fellow can begin to moonlight. These meetings are held the third Wednesday of each month, and completed forms need to be submitted to OGME at least a week in advance. For example, if a fellow decides on March 23 s/he wants to moonlight, the start date on the form would need to indicate April 22, the day after Wednesday April 21, when the GME EC meets. (Assuming that moonlighting is approved, the fellow would then be able to moonlight beginning April 22.) The completed form itself would need to be submitted to OGME no later than Wednesday April 14, a week prior to the GME EC monthly meeting. GME request forms must be submitted on a yearly basis for continuous updates. THE FORM MUST BE ORIGINAL AND NOT A FAX.

This policy pertains to fellows within GME and not to medical staff fellows. (Requirements apply to medical staff fellows – this is arranged between the fellow and the site of moonlighting activity; however, GME fellows must comply per GME protocol by submitting a request form and be approved to moonlight during the time they are appointed to housestaff.) **Thus, a medical staff fellow coming into the GME program in July needs to have moonlighting approval in place by the July start date so that continuity of care is not interrupted. This means that fellows should submit requests 2-3 months prior to the July start date.**

In addition to the site of moonlighting activity requested on the form, other ongoing sites must be listed. In the case of Central Regional Hospital and Dorothea Dix (two separate entities), if a fellow is to moonlight in both places, two separate request forms would need to be submitted.

The fellowship coordinator makes sure the form gets signed and submitted to OGME. OGME will then notify the coordinator once the fellow is able to begin moonlighting.

Locations

If a fellow is interested in moonlighting at Central Prison Hospital, shifts are available for Sunday – Saturday 7:00 p.m. to 7:00 a.m. and Saturday, Sunday and holidays from 7:00 a.m. to 7:00 p.m. Help is generally needed on Fridays, Saturdays, Sundays, and holidays. The regular rate is \$70 per hour; the holiday rate is \$96.25 per hour. If interested, please fax your cv to Glenn R. Schweinsberg, gschwein@neshold.com, of NES International, Inc., and NES Government Services, Inc., <http://www.neshold.com>. Fax includes 1-757-420-6616. Phone numbers include 1-800-181-1813 x 203; 1-800-637-3627 x 203; 1-757-420-7985 x 203. The person to contact directly at Central Prison is Mary Gearhart of the Managed Care Division at 919-733-0800.

Dorothea Dix pays \$90 per hour. Contact person is Dr. Scott Mann (scott.mann@dhhs.nc.gov) at Dorothea Dix Hospital, 3601 MSC Center, 5E Medicine Division, McBryde Building, Raleigh NC 27699-3601, phone 919-733-0742. Contact individuals at Dorothea Dix also include Gail Lewis at 919-733-0742 (gail.lewis@ncmail.net) and Delores Foster (Dolly) at 919-733-0740 (dolores.foster@ncmail.net). Mosella Jamerson is the Human Resources Director.

NOTE: Fellows need continuation of ACLS certification to moonlight at Dix.

Dr. Mann will need a letter of approval from the program coordinator for medical staff fellows not presenting with formal approval from OGME.

Because of delayed payments between the Comptroller's Office at Dix and the circuitous manner in which payment is received first at the UNC Budget Office, then UNC Payroll, then Medicine Payroll, as of 5/9/10, administrative officials at Dix have agreed to put moonlighting fellows on their state payroll system (Beacon) so that payments can be made directly to the fellow. This should make the process less cumbersome and more expedient. The payroll specialist there is Debbie S. Thomas. Her email address is Debbie.S.Thomas@dhhs.nc.gov.

Marvellena L. Grantham (Marvellena.Grantham@ncmail.net) serves as the credentialing coordinator for WakeMed Health & Hospitals (phone 919-350-8114; fax 919-350-7472).

Dr. Stephen Oxley serves as Clinical Director at Central Regional Hospital (phone 919-764-7300, fax 919-764-7338). CRH is located at 300 Veazey Road, Butner, NC 27509. Contact individuals include Kelly Breedlove (kelly.breedlove@ncmail.net) and Vicki Bryant (vicki.bryant@ncmail.net), phone 919-764-7230, fax 919-764-7250. Judy Leonard (judy.leonard@dhhs.nc.gov) serves as administrative assistant to the Director of Medical Services: phone 919-764-2330; fax 919-764-2374.

The Department of Veterans Affairs VA Medical Center is located at 508 Fulton Street, Building 16, Room 48, Durham, NC 27705, www.myhealthva.gov. Contact individuals include Deborah Zakrzewski, medical staff coordinator, and Melinda Orr or Sherry Harrell, credentialing specialists, at 919-286-0411, ext. 7100 and 7824, respectively.

Durham Regional Hospital located at 3643 North Roxboro Road, Durham, NC 27704. Contact person is JoAnn White, at 919-470-8490 (office), 919-470-8555 (direct number), 919-470-8469 (fax), email joann.whittle@duke.edu. The going rate is \$1,500 per shift (\$125 p/hr).

NOTE: Fellows need to apply for an individual DEA number in order to moonlight at DRH.

In August of this year, Fayetteville VA Medical Center began soliciting positions for capable hospitalists/fellows who have their basic specialty training. The proposed rate is \$175 per hour, and the shifts are 12 hours, although they can be modified. Please note that Fayetteville VA is one of our ACGME participating sites so that any moonlighting done there by our GME residents is internal and must count toward the 80-hour limit, with these hours recorded in E-Value. Professional liability insurance from the VA would also be needed. Those interested in this moonlighting opportunity should contact Dr. Michael Rynne, email Michael.Rynne2@va.gov, cell 910-322-5894.

Additionally, in the past Annington Hospital in Reidsville, NC, has needed a locus tenens physician for weekend GI coverage, which includes rounding on current patients, consults, on-call coverage and emergent procedures. Contact person is Marlene Yates, Director of Medical Staff Development, 336-634-4588, marlene.yates@mosescone.com. They ask for only third-year/senior fellows for this position.

One fellow – upon the recommendation of another fellow – found moonlighting opportunity through a company called Moonlighting Solutions. The contact person is Mandy McCoy, mandy.mccoy@moonlightingsolutions.com. This agency recruits for multiple hospitals within NC.

We discourage moonlighting activities for at least six months until the subspecialty resident is familiar with our fellowship program and can manage moonlighting responsibilities in addition to those duties expected by us. Often research fellows moonlight initially because they are not on clinical service and can accommodate moonlighting hours into their schedules. Clinical fellows are strongly urged not to moonlight during consult blocks.

NOTE: Fellows on J-1 visas are not permitted to moonlight. Since this visa is intended for visiting student trainees, trainees must focus on clinic and research time required of the training program in which they are enrolled; thus, no external or professional activities are allowed.

DUTY HOURS

All fellows within the GME component of our program must report duty hours on a weekly basis through our E-Value system. Duty hours include the following:

- All time spent in the hospital setting related to patient care, including rotations and clinic time. This also includes internal moonlighting hours in our hospital setting, such as in the ER or hospitalist service. NOTE: Rex is now part of UNC Healthcare.
- Time spent in another location for subcontracted services as part of our educational program (none contracted at present).
- Moonlighting hours spent away from our hospital setting, such as at Central Prison.

Duty hours DO NOT include the following:

- Clinic-related time not spent in the hospital setting, such as time spent dictating clinic notes by phone at home.
- If you are on night or weekend call and are at home, this time does not count unless you come into the hospital; then you count the time you spend while on call in the hospital setting.
- Food cards are not issued to our subspecialty residents. In order for a resident to be issued a food card, s/he has to spend at least a 24-hour stretch period in-house call.

Residents must not spend more than 80 hours per week in patient care duties, including internal and external moonlighting hours. These are guidelines set in accordance with the ACGME standards.

GME fellows must report duty hours for each day of the week in the E-Value system, whether they actually worked or not. Planned hours can be keyed in ahead of time. On each Wednesday of the week, the program coordinator is sent a notice of who has been delinquent in reporting hours for the previous week. The coordinator then sends those fellows a reminder to report their hours. Fellows who are reported to be at 7 days in delinquency are not notified because of the lag that can occur surrounding report generation, which takes place early each Wednesday AM. Since GME fellows have been moved to the hospital payroll (although still salaried by us), a fellow delinquent 21 days in reporting can face sanctions, including withholding of pay and being pulled from clinical duties.

Fellows must report all moonlighting hours – both internal and external – towards the 80-hour work week in the E-Value system, as this professional activity – regardless of site – can adversely impact fellow performance.

DUTY HOURS FOR UNC GASTROENTEROLOGY & HEPATOLOGY

The on duty hours for the different rotations vary as follows:

GI Consults: 8 AM to 5 PM, Monday through Friday. If the fellow is not on call for the weekend, s/he will round on consult patients Saturday morning. Sunday is covered by the consult attending.
Weekly duty-hour estimate: 70-75 hrs

Liver Consults: 8 AM to 5 PM, Monday through Friday. If the fellow is not on call for the weekend, s/he will round on consult patients Saturday morning. Sunday is covered by the liver consult attending.

Weekly duty-hour estimate: 65-75 hrs

Clinic Rotation: Hours are 8 AM to 5 PM on weekdays

Weekly duty-hour estimate: 40-50 hrs

Endoscopy Rotation: Hours are 8 AM to 5 PM on weekdays

Weekly duty-hour estimate: 40-60 hrs

Biliary Rotation: Hours are 8 AM to 5 PM on weekdays with on call for biliary procedures during off hours. This is at home call.

Weekly duty-hour estimate: 60 hrs

On Call:

The on-call fellow covers emergent GI and liver consultations from 5:00 PM until 8:00 AM on weekdays. Weekend call starts at 5:00 PM on Fridays until 8:00 AM on Monday. Call is taken from home. The fellow will come in to see new consults or old consults that are having difficulty. In addition, during the on-call hours the fellow will take outside calls from GI patients asking for the GI physician on call. Any emergent endoscopic procedures that need to be performed during these hours are done by the on-call fellow and the on-call procedure attending. The GI fellow on call is supervised by the consult attending. The clinical fellows divide call equally among the group. The minimum number of fellows that this is split between is four, and more commonly six. This equates to every 4th – 6th night call and every 4th to 6th weekend on call. Because our fellows do not take in-house call, we have no call room; however, call rooms are located on the hospital floors.

INJURY/WORKER'S COMPENSATION

If a fellow sustains a work-related injury, s/he should file an **employee accident report form** as soon as possible (NC Industrial Commission Form 19). Without completion of this form, no bills will be paid related to the incident. This form should be sent to Al Doherty (al_doherty@unc.edu) of the UNC Health & Safety Office, CB# 1650, 2-5710. An **employer's report form** (NC Industrial Commission Form 18) should be filed *within five days after knowledge of the incident*. It is the fellow's responsibility to notify the program director, coordinator, or division administrators of such an incident. The employer's claim should be forwarded to the NCIC (North Carolina Industrial Commission) – Statistics Section 4334, Mail Service Center, "Raleigh, NC 27699-4334 (919-807-2500, 1-800-688-8349). A fellow appointed through Medstaff can visit the University

Employee Occupational Health Clinic, 6-9119, located in the Ambulatory Care Center (ACC), fax number 6-6337; a subspecialty resident appointed through Housestaff can visit the Hospital Occupational Health Clinic, 6-4480, located at 1088 West Wing, fax number 6-6326.

If the fellow disagrees with the description or time of the accident on the NCIC Form 18 (employer's report), the fellow must make a corrected written report to the employer within 30 days. Form 18 'Notice of Accident' must be filed **within two years** of the initial date of the injury.

HEALTH INSURANCE AND DISABILITY

Subspecialty residents appointed through Housestaff as well as fellows appointed through Medstaff should contact Debbie Hamilton of UNC P & A (3-8609, CB# 7150, Debbie.Hamilton@unc.healthcare.org) for questions regarding health insurance and disability.

Subspecialty residents appointed through Housestaff do have the option of obtaining life and dental insurance.

Dental Faculty Practice: The Dental Faculty Practice (DFP) of the UNC-CH School of Dentistry includes faculty members of our School of Dentistry who provide dental care for patients. Because this practice provides both general and specialized dental care, individual needs determine the dentist one sees for diagnosis and/or treatment. Complete care may necessitate appointments with more than one faculty member. Patients within DFP are treated exclusively by dentists who are full-time faculty members of the UNC-CH School of Dentistry. Anyone who is not committed to another dentist may become a comprehensive care patient in the Practice. Individuals who have received dental treatment in the UNC-CH School of Dentistry Student Clinics in the past 12 months are not permitted to become patients in the DFP, except when specialized care beyond the capability of students is required. Appointments may be made by calling 6-2115. In the event it becomes necessary to cancel an appointment, an advance notice of at least 24 hours is requested. Any appointment not cancelled 24 hours in advance is considered a broken appointment, and a fee may be charged. The Practice is open Monday through Friday from 8:00 a.m. to 5:00 p.m. DFP fees are comparable with fees charged by outside generalists and specialists. Patients are encouraged to request fee estimates from their dentist prior to treatment. Fees quoted for treatment do not necessarily include consultation fees. Payment for all treatment is required at the time of service, either by 1) cash account (cash, check, Mastercard or Visa), 2) payment plan, or 3) insurance.

Once a fellow appointed through Medstaff has enrolled in an insurance program, this stays the same unless the fellow indicates otherwise, which s/he can do at the time when renewal papers are sent on a yearly basis. If a fellow does switch, s/he needs to make sure not to receive multiple insurance cards—only one card is issued. This may occur, too, if funding is switched from benefits being paid from our training grant to our clinical one.

For fellows appointed through Medstaff, the State Plan does not offer dental or visual insurance. (Ms. Hamilton does not deal with or know about these things.) In this case, the fellow can contact Partner's Health Insurance at 1-877-494-7647. This is the insurance company UNC uses for supplemental insurance of this kind. The State Health Plan's web site is <https://statehealthplan.state.nc.us>, 1-800-422-4658; UNC Human Resources web site is <http://www.ais.unc.edu/hr/>. We also provide a long-term disability insurance plan underwritten by the UNUM Life Insurance Company of America.

In addition, since fellows appointed through Medstaff are considered temporary and not permanent employees, fellows are not permitted to enroll in the NC FLEX Program.

LIABILITY INSURANCE

All subspecialty residents and fellows who are clinically active receive professional liability/malpractice coverage through UNC Liability Insurance Trust Fund through UNC P & A *for the duration of time they remain clinically active and maintain clinical privileges*. For those leaving our program who must go through the process of licensing and credentialing elsewhere, our limit is \$7,000,000 per individual as an occurrence-based policy. There is no policy number because, as a trust fund, we are self-insured. The address to put for the UNC Liability and Insurance Trust Fund is: Legal Dept., 6001 East Wing, UNC-Hospitals, 101 Manning Drive, Chapel Hill, NC 27514. Often a hiring agency requires a claims history/certificate of interest form, in which case the fellow or coordinator must contact Angela Orlando of the Risk Management Office at 6-3041, aorlando@unch.unc.edu. She, or someone from her office, would fax this information to the necessary party. Of note, Cigna is the provider for Medicare; Humana/TriCare is our state military health plan. For questions regarding Cigna paperwork, contact UNC P & A Managed Care at 3-6943.

Generally, fellows requiring credentialing elsewhere are asked to provide four main documents:

- claims history
- certificate of interest form
- sponsorship of current professional liability coverage
- type and number of GI procedures performed, including an attestation thereof

MANDATORY COMPLIANCE TRAINING

The UNC School of Medicine Compliance Office requires that all medical faculty and staff who see patients and/or bill attend a training session concerning physician regulations on proper documentation and coding of evaluation and management (E & M) services. Although attendings bill and are required by Medicare to write a summary clinic note in order to do so, it is the fellow who dictates (writes) the major bulk of the medical documentation. These training sessions are offered twice in August and twice in March by Chris Agosto, training coordinator. Generally, if a fellow did a residency here, s/he probably has already attended this training session and does not need to attend it again. Once a fellow attends a training session, s/he does not have to attend additional ones. This compliance has been in effect for attendings but was not put into effect for residents and fellows until 1/2000. However, some fellows who did residency here may have already attended a training session as it was optional prior to 1/2000. If a fellow did a residency elsewhere, though, s/he is required to attend a training session at UNC. If s/he fails to do so, s/he will be contacted by the Compliance Office until the requirement is met. If anyone has questions, s/he can contact Heather Scott of the Compliance Office at 3-8638 (fax 6-7564). The Compliance Office is located in 61 MacNider Building, CB# 7000.

IMMUNIZATION SCREENING AND ANNUAL TUBERCULOSIS TEST

UNC requires that all faculty and fellows have an appropriate immunization screen for mumps, measles, and rubella at the time of initial employment in addition to an annual skin test for tuberculosis. The TB skin test must be read 48 hours after it is placed. University regulations state that a physician cannot interpret his or her own skin test. Faculty and fellows must go to the University Employees' Occupational Health Clinic (UEOHC) in the Ambulatory Care Center (ACC) to have the immunization screening and yearly TB skin test. Although subspecialty residents are appointed through Housestaff, they go to UNC Occupational Health for all necessary needs because their salaries are paid from the Department of Medicine and not from the hospital. An employee's status (either UNC or hospital) is determined by the source of salary funding.

Additionally, to satisfy occupational health requirements, UNC faculty and fellows must complete annual tuberculosis refresher training, annual bloodborne pathogens refresher training (required if only exposed to blood or other potentially infectious materials), and annual healthcare/JCAHO worker general safety training.

The tuberculosis and bloodborne pathogens training requirements may be satisfied by one of the following:

- Attending training sessions conducted by UNC Health and Safety or UNC Hospitals.
- Completion of the self-instructional courses on the UNC Health and Safety web site at www.hsafety.unc.edu.
- Completion of the self-study packets and forwarding the tests to UNC Health and Safety.

The healthcare/JCAHO worker general safety training may be satisfied by one of the following:

- Completion of the self-instructional course on the UNC Health and Safety web site at www.hsafety.unc.edu.
- Completion of the self-study packet and forwarding the test to UNC Health and Safety.

Subspecialty residents comply with immunization screening and the annual tuberculosis test as part of their reappointment to the UNC Housestaff. Housestaff requires this as a part of the reappointment process.

As of 1/1/04, all housestaff residents are required to have annual TB mask fit and testing (now federal law). Do not drink any liquids (other than water) or eat 45 minutes prior to mask fitting. The mask will be tested for efficacy, after which the resident receives a certificate. Housestaff must receive this certificate, with a copy given to the coordinator for the resident's file. Housestaff does not permit a resident to continue training if this test is not done annually. At the designated time, the resident is to contact University Occupational Health at 6-9119 on the 1st floor of the ACC Building to set up an individual appointment for this requirement. If the resident has any questions, s/he can contact Mary C. Crabtree at 2-5719 or mcrabtree@email.unc.edu. 3M masks must be ordered through Thermofisher Scientific, www.thermofisher.com, through Evelyn Burnette, our UNC representative and site specialist @ phone 3-5604, fax 3-5605, email Evelyn.Burnette@fishersci.com. The Fisher catalog number for this mask is NC9041782, and the 3M vendor part number is 1870.

REPORTING OF COMMUNICABLE DISEASES

In accordance with Public Health Law, certain communicable diseases are to be reported to the North Carolina State Health Department. **By law it is the physician's responsibility to complete a Communicable Disease Report Card and any additional surveillance forms in a timely and accurate manner.** This card is available on every nursing unit. Each card indicates which diseases must be reported within 24 hours (by telephone) or within seven (7) days (by mailing the card or returning it to the unit secretary, who will forward it to Hospital Epidemiology, Room 1001, West Wing, CB# 7600). Shaded areas indicate diseases for which additional surveillance forms should be completed. Listeriosis was made a reportable disease in North Carolina as of June 1, 2001; until the Communicable Disease Card can be modified, write in the word "listeriosis" in the square in the upper left corner of the card.

SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS OR MEMBERS OF THE HOUSEHOLD

It is the position of the North Carolina Medical Board (NCMB position statement “Physician Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist,” 5/2000) that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. “The Board strongly believes that such treatment and prescribing practices are inappropriate and may result in less than optimal care being provided.”

Consistent with this Position Statement, it is the policy of UNC Hospitals that physicians on our medical staff should refrain from self-treatment and the treatment of family members or members of their household at UNC Hospitals. UNC Hospitals expects physicians to delegate medical and surgical care of themselves, their families, and members of their household to one or more of their colleagues in order to ensure appropriate and objective care. This delegation includes ordering diagnostic laboratory or radiological testing as well as treating or prescribing for medical conditions.

It is further the policy of UNC Hospitals that nursing and ancillary staff will not accept physicians’ diagnostic, treatment, or prescription orders for themselves, their family members, or members of their household.

CONFLICT OF INTEREST

Each year faculty, fellows appointed through Medstaff, and post-doctoral fellows are required to complete and submit October 1 an annual evaluation form “For Possible Conflict of Interest or Commitment with UNC Chapel Hill.” This form can be completed and submitted either electronically at <https://www-s3.ais.unc.edu/coi/> or in paper form to the Office of University Counsel at CB# 9105, Suite 300B, Bank of America Building, 137 East Franklin Street.

In the past, some individuals have experienced difficulty with the electronic form per above. If there is a problem with one’s ONYEN (university) account, s/he can go to the ‘printable form’ (includes definitions) to print out a hard copy of the form. One can print a hard copy of the form by going to <http://coi.unc.edu> and mail it to University Counsel instead of sending it to this Office electronically. The form is in PDF format; to view or print it in this format requires the Adobe Acrobat plug-in (downloadable). You must use Internet Explorer and not Netscape.

Completion of this conflict of interest form is required of all faculty and fellows because it contains information that may have a direct bearing on employment; thus, filing this form is a condition of one’s employment. The form is included in one’s personnel file and is considered strictly confidential. The information disclosed in the form is available only to individuals duly charged with the responsibility for review and may be released only in accordance with and as required by federal or North Carolina law or regulation or lawful court order. If you have any questions, you may contact Erika Nunn at the Office of University Counsel, Erika_Nunn@unc.edu, phone 2-1219, fax 3-1617.

The fellowship coordinator oversees issues of conflict of interest within the division. If you would like to read the policy in detail, the coordinator keeps a copy on hand. However, the policy in its entirety can be found at <https://www-s3.ais.unc.edu/coi/index.html>.

In addition to ‘conflict of interest’, there is what we call ‘conflict of commitment’. This term relates to how much time one spends between university duties versus professional outside activities. Employees are expected to remain focused on the missions of the university and to maintain

loyalties to the university. If one engages in external professional activities for pay, s/he must complete and file with the Department of Medicine Chair's Office a "Notice of Intent to Engage in External Professional Activity for Pay." This form must be filed at least ten days before the commencement of the activity in question, and the activity must be approved by the university. The form and policy can be found at <http://www.unc.edu/policies/externalpolicy.pdf>.

UNC VOICE MAIL

To set up UNC voice mail, you must first create a six-digit numeric password. To do this, dial UNC voice mail at 2-6200. When you hear the prompt, press 4 (personal options). To set up a password, press 2 (administrative options), then 1 (general), then 1 (passwords), then 1 again (personal passwords).

After you have created a password, to leave a voice message, after you enter your password, press 4 (personal options), then 3 (greetings), then 1 (personal greeting), then 2 (personal), then 1 (away from phone).

If you need an individual phone installed, it depends on the source of funding as to whether or not this can be done. There have been instances where an individual was without a personal phone in his or her work area because of insufficient funds. However, some individuals have been able to have phones because of funding from other sources such as our training grant or from a faculty member's start-up funds or trust fund account. For assistance, you may contact Laura Cooper at 2-4191, LMC@FAC.UNC.EDU or refer to <http://www.telecom.unc.edu/services/voicemail.php> and navigate to links at the bottom of the page.

PARKING

Subspecialty residents appointed through Housestaff are assigned parking through that office, generally at Craige Deck. Subspecialty residents receive an emergency parking permit along with their housestaff parking permit. Questions can be directed at the Housestaff Office (6-1072) or at hospital parking services on the second floor of Neurosciences Hospital, in the same area where employees obtain their hospital ID badges (James Dean, phone 6-1031, fax 3-0111).

For those appointed through Medical Staff, each year, Medicine allots Gastroenterology so many parking spaces (and their locations) for faculty, fellows, and staff. The parking cycle runs from August 14 through August 15. Parking request forms must be filled out in April for the new cycle; however, only current employees can obtain parking permits or renew parking permits. For employees who are supposed to join Gastroenterology at a later date, parking permits cannot be obtained beforehand. Upon their arrival, new employees can obtain a temporary parking permit through UNC Parking (UNC Public Safety) by calling Lisa Hierman for permit registration at 2-5033. (If one wishes to appeal a citation, s/he can contact Cheryl Baber at 2-3953.) One may also visit the parking office, which is located across the parking lot facing the Emergency Department of Neurosciences Hospital to the right of Morrison Dormitory. When you are applying for a parking permit, please remember to make note of your license plate number. *It is important that you put the correct plate number, state, make of vehicle, year, and color on your parking permit application because this is what is used to match the space with the car; if this is not correct car, you may be ticketed and/or towed.* You may designate more than one vehicle for an application. If you change vehicles, be sure to notify Parking so that your permit can be modified accordingly.

Once a new employee has obtained a temporary permit, this will be usable through 8/14, at which time the new employee must renew parking for the full cycle beginning 8/15. The employee must

pay out of pocket (cash or charge card) for a temporary parking permit but can have the full parking permit deducted from payroll per authorization.

If a person is renewing a parking permit for the new cycle, s/he is not guaranteed the same parking space, although s/he can request this on the application, nor do we know beforehand what particular space a person has been assigned. Traditionally the location of parking spaces per person was determined by 1) longevity and 2) position but is now determined by salary. For residents making under \$50,000 per year, the cost is \$602.00 per year in Craige Deck. If the resident makes \$50,000 or over per year, the cost is \$760.00 per year in Craige Deck.

A UNC One Card is required to obtain a parking permit. This card can be obtained through the UNC One Card Office located on the ground floor of the Student Bookstore on the main campus, 2-8024. You need to show picture ID (driver's license) for this as well as give your PID # (UNC employee ID number), which Robyn Catlett can provide you if you do not know it

(robyn_catlett@med.unc.edu, 6-0775). Some employees live close enough to walk or to ride a bike and do not purchase a parking permit. Some employees park in private lots close to campus and walk in to work. (Notify Steve Kennedy, skennedy@med.unc.edu, 6-2514, in this regard.)

The cost of parking varies depending on the location of the parking space, with closer spaces costing more than ones farther away, and ones located in parking decks costing more than those not located in parking decks. The charge of a temporary permit is prorated by how many days it is used prior to 8/15. (For example, \$27 for Craig Deck and \$37 for S11.) A yearly permit costs an average of \$365, and the cost is subject to change yearly, with a slight increase.

If an epidemiology fellow is doing an MPH track for the year, s/he can apply for parking through the School of Public Health, where s/he may be able to obtain a permit in a better zone.

HOW TO COMPLETE YOUR PARKING PERMIT APPLICATION

- Indicate your PID # in the upper left hand, a nine-digit number (four digits hyphenated by five digits) indicated on your UNC One Card.
- State your name.
- Employee Status: Circle *full-time* and *fellow*.
- Department Name: Medicine/Digestive Diseases
- Department Number: 4228
- Department Phone Number: 6-2514
- Work Schedule: M-F 8-6 or preferably 7 days/24 hours
- Building: Burnett-Womack, CB# 7080
- Leave Shop # blank.
- Give your home address.
- Permit Zone Requested: List three parking zones in order of preference. (Some people state only one zone; some state two of the same and a different third one; some state all three as the same, etc.) Parking provides a map designating the location of the various parking zones.
- Enter necessary information as indicated for each vehicle.
- Payment Method: Generally circle 'Payroll Deduction'.
- Deduct Permit With Pre-Tax Status: 'Yes' if you specified 'payroll deduction'.
- Sign and date your name.

EMERGENCY PARKING

Parking spaces are provided for immediate access to patients, with a limit of up to four hours. These spaces must be used for providing *bona fide* emergency patient care. **The definition of emergency should be when minutes would make a difference in the treatment of a specific patient.** The UNC-Hospitals Police Department has been instructed to ticket those found to be using the emergency spaces on a regular basis (for routine returns to the hospital or for urgent or routine patient care). Persons found violating this privilege will have their emergency parking restricted or suspended. If everyone cooperates in a constructive manner, the reserved emergency parking spaces will be available for what they are intended. Fourteen (14) emergency parking spaces (designated as such), which is adequate for emergency parking if everyone follows these guidelines. These are located in the following areas:

- Four (4) parking spaces are opposite Medical Records
- Three (3) are located to the curb next to the Blood Bank
- Four (4) are located along East Drive
- Three (3) are located in the Emergency Department parking lot.

The permit must be displayed on the driver's side of the dashboard of your vehicle with the number clearly visible. The permit is not valid in any area or space other than those designated for EMERGENCY STAFF PARKING.

Any permit lost or stolen must be reported to the UNC-Hospitals Police Department by calling 6-3686. Once reported lost or stolen, a permit will be deleted from active records so that the person attempting to use the permit will be subject to receipt of a parking violation citation.

Additional parking has been made available in the CG LOT below the site of the old helipad in front of the Main Hospital across from the parking deck. For this lot, the following guidelines apply:

- Parking will be permitted in the CG Lot from 5:00 p.m. to 6:00 a.m. daily.
- A key pad has been installed on the gate to the CG Lot, which is programmed to accept a code number (0500) to allow entry into the lot. (All four digits must be keyed in.)
- The emergency parking permit must be displayed on your vehicle while it is parked in the CG Lot during the hours between 5:00 p.m. and 6:00 a.m.
- Emergency parking permit holders will be allowed to park in the CG Lot during the above-stated hours for both bona fide as well as other patient care-related responses.
- Vehicles displaying emergency parking permits must be removed from the CG Lot by 6:00 a.m. daily unless that vehicle has a CG permit displayed.
- Campus parking monitors will patrol the CG Lot and will issue citations to vehicles not displaying a CG permit remaining in the lot after 6:00 a.m.

For questions about parking, please contact Lauren Phillips of Medicine at 3-6350, lbp@med.unc.edu. Of note, some individuals have contacted Felix Stevens at the UNC Department of Public Safety by emailing him at FELIX@DPS.PSAFETY.UNC.EDU in regard to undesirable parking space assignments. In regard to event parking, one can email Randy Young at RANDY@DPS.PSAFETY.UNC.EDU, visit the web site per below, or call 2-3951, which is in service 24 hours a day. The UNC Parking (Department of Public Safety) web site is www.dps.unc.edu. DPS now publishes its own monthly newsletter called "The Word on the Street" (WOTS) at the aforementioned site by browsing through the "Publications" link from the home page.

TRANSPORTATION and PUBLIC SAFETY

In addition to permits for gated and non-gated parking areas on campus, hospital shuttle (free of charge) runs from the bottom of Manning Drive (Family Practice Center) to the Ambulatory Care Center (ACC). Chapel Hill Transit offers extensive service (free) on and around UNC, including Park & Ride service from UNC's P and PR parking lots, and from Carrboro Plaza, Southern Village, Eubanks Road, Franklin Street (Masonic Lodge), Highway 54, and Jones Ferry Road parking lots. There is also Chatham Park & Ride on the way to Pittsboro, serviced by Carolina Livery (Triangle Professional Transportation Services), 957-1111. For route and schedule service information, call the Chapel Hill Transit Office at 968-2769 or consult the website www.ci.chapel-hill.nc.us/transit/. For issuance of a disability parking permit, one must apply for such a permit and include physician certification. The fee for the permit is the price of the zone, as determined by Public Safety.

Point to Point Shuttle runs seven days a week during the spring and fall academic semesters (except University holidays or when residence halls are closed), the P2P Express offers free, fixed-campus-route transportation to all students and employees. The hours of service are 7:00 p.m. until 3:00 a.m. each evening. You can consult www.dps.unc.edu for a detailed route map and updated schedule.

The P2P On-Demand Shuttle provides daytime transportation for students going to the Student Health Services Center. This service also provides transportation for all disabled students and employees. After dark, P2P provides transportation to and from remote on-campus parking lots and the P and PR lots off campus. One-touch direct-line call boxes are located in the Manning (S11) Lot, Bowles (S11) Lot, Craig Deck (CD), and the P and PR parking lots. On-demand service is provided 24 hours per day during weekdays and from 9:00 a.m. through 5:00 p.m. and 7:00 p.m. to 5:00 a.m. on weekends.

Triangle Transit Authority (TTA) comprises a system of bus routes operated by the Triangle Transit Authority (TTA), connecting Raleigh, Durham, Chapel Hill, Cary, the Research Triangle Park (RTP), the area's universities and hospitals, and Raleigh-Durham International Airport. For information on bus routes, schedules, fares, and pass prices, please call the TTA Regional Office at RTP, 919-549-9999 or visit their web site at <http://www.ridetta.org>.

UNC and the TTA are working together to help UNC and UNC Healthcare employees and students explore carpool and vanpool opportunities. For more information on car and vanpooling, contact Debby Freed of Transportation Demand Management at 3-4414, visit our Department of Public Safety web site at www.dps.unc.edu, or call TTA at 919-549-9999.

Bicycle parking is available throughout campus and is designated by the presence of bicycle racks. UNC and UNC Healthcare employees are encouraged to affix a bicycle registration permit. This permit is free upon completion of a bicycle registration form, provided by the Department of Public Safety.

Purchase of a motorcycle permit is required for any licensed two-wheeled vehicle, such as motorbikes and mopeds. A motorcycle permit (MC) costs \$149.00 for employees and \$140.00 for students per year. An individual who wishes to register both a car and a motorcycle must list all license plate numbers on the same application; car and motorcycle registrations must indicate the same owner. In this case, applicants pay full price for their car permit and \$34 (under \$50,000 per year salary) or \$38 (over \$50,000 per year salary) for the motorcycle permit. In order to receive a motorcycle permit, owners must provide proof of liability insurance for their motorcycle, including

insurer, policy number, and policy expiration date. Licensed mopeds and motorbikes park in designated motorcycle parking areas.

Operators of unlicensed mopeds and motorbikes are encouraged to register their vehicles with Public Safety, as they should with a bicycle, as a deterrent to crime and an aid in identifying lost or stolen vehicles.

The Commuter Alternatives Program (CAP) was created in an effort to reduce traffic congestion and the number of vehicles parked on campus. CAP rewards UNC employees and students who do not drive a single-occupancy vehicle (SOV) to commute to campus. The program is free and requires that the CAP registrant commute to campus and not hold an SOV parking permit. CAP registrants can take advantage of such incentives as Emergency Ride Back transportation, offered from campus to park and ride lots or other local sites in situations of urgency. In an emergency, park and riders should contact the Emergency Ride Back dispatcher at 3-7671 for transportation to their own vehicles. CAP encourages all forms of alternative transportation, including walking, bicycling, transit use, park and ride, and car and vanpooling. For more information, call the Department of Public Safety at 2-3951 or visit www.dps.unc.edu.

Starting in 1/1/04, the UNC campus became home to four Zipcars, all new silver Volkswagen Beetles. This fleet provides students, faculty and staff an alternative to bringing personal vehicles to campus. Departments do not have to pay for a service vehicle to do campus-related business, and employees who do not drive to campus can use the car to run occasional errands. Zipcar is meant to provide short-term access to a car when public transportation, walking or bicycles is not practical. Usage rates for the UNC community are \$5 per hour, which includes 125 free miles per registration, per day with a maximum daily rate of \$80. If the car's gas gauge goes below one-fourth of a tank, a special card allows the use to refill the tank. The annual membership fee of \$20 is converted into driving credit if used within 30 days. Zipcar members make reservations on line, walk to the closest available Zipcar location, unlock the car with a Zipcard and drive away. Members have access to use Zipcars in other cities when they are traveling. An on-board computer tracks all usage information, and billing is automatically linked to the member's credit card. Only the member who has made the reservation can use the car. As a means to reduce traffic on campus, Zipcars are a supplement to the Commuter Alternatives Program (CAP). There is a Zipcar located in the CG parking lot in front of the main hospital, across from the Cardinal parking deck. For more information on Zipcar, go to www.zipcar.com/unc.

Safe pedestrian access to the University depends on extra care by both pedestrians and motorists. One can contact the Pedestrian Hotline at 3-7337. Additionally, there are over 100 UNC Police Emergency call-boxes located on campus. Pushing the button to activate a police call box immediately places the pedestrian in touch with UNC Police. Upon the placement of any call, the bright blue flashing light atop the call box will automatically activate. Do not stay at the call box if you feel threatened—a UNC Police vehicle will be dispatched, even if you do not respond. Use the call box to report any activity on campus you find suspicious. For emergency calls (area police and fire emergencies), dial 911, Campus Police 2-8100, or UNC-Hospitals Police 6-4111 (medical emergencies) or 6-3686 (request for dispatch of service).

Remember when walking at night, plan the route in advance so you can stay in well-lit areas near call boxes; stay alert to your surroundings; and avoid walking alone. Tell someone or leave a note as to where you are going and when you expect to return. Weather permitting, a guard is stationed to the right of the overpass walkway going from the main hospital to the Cardinal (Employee) Park Deck, and, at the end of the garage on the other side coming out on to Mason Farm Road across from Bioinformatics, there is a campus police substation to the right.

UNC Public Safety Information includes:

- General Information and Customer Service: 2-3951, 2-3952; fax 2-2572;
<http://www.dps.unc.edu>
- Customer Service Hours: 7:30 a.m. – 5:00 p.m. Monday – Friday, Public Safety Building
- Parking Services 24-hour Information Line: 558-5960

A Falcon Ride provides area transportation services to and from Chapel Hill, Carrboro, Research Triangle Park, Durham, Raleigh, RDU Airport, and Cary. The number is (919) 309-2700, and their web site is www.AFalconRide.com. Jannie's van pool service also provides local transportation, 515-5100.

After Hours: We have night shuttles, serving the campus and park and ride lots, available from the Children's Lobby starting at 5:30 PM. If the shuttle is not parked in front of the Children's entrance, a Guest Services staff member at the Information Desk can call for a shuttle. The Visitor Deck (Dogwood) is available from 5 PM – 9 AM M-F and 24-7 on weekends, with a parking permit or park and ride sticker.

LAUNDRY

Fellows may have their lab coats cleaned by putting them in the fellowship coordinators' tray in their space. The coordinator transports them to Tiffany Eubanks, 3-1072, tiffany_eubanks@med.unc.edu, who is responsible for the laundering of lab coats. Laundry is picked up each Tuesday a.m. and returned on Thursday a.m. For issues involving repair (such as replacing a missing button) or defects (the bleach washing out the color of the script), please voice your concern to the coordinator. Tiffany keeps a bin by her area (4160F Bioinformatics) where people can put their lab coats for laundering. If you have not received your lab coat back from laundering when expected or within a reasonable amount of time, please notify her.

There have been complaints of our laundry service staining lab coats and causing colors to fade; the coordinator has attempted to remedy this situation, but it continues. In this case, a fellow may want to take care of laundering his or her lab coats, as some do. In any case, make sure to empty all pockets of loose change, paper clips, etc. before laundering. If you have a coat with no name stitched on it, write your last name with a permanent marker, either on the tag or inside collar of your coat.

LAB COATS

Fellows are allotted two lab coats per year during their training with us as long as they are involved in clinical activities. While one coat is being laundered, the other coat should be used. Coats come in two types, the thinner Landau with plain buttons, and the thicker Angelica with knot buttons (preferred type). Name, title and division are embroidered either on the right or over the left pocket (preferred), either in block or script (preferred), in five different colors: red, green, royal blue, Carolina blue (preferred) and black (preferred). If a fellow wishes to have additional lab coats determined not necessary by administration, s/he may solicit funding from another source or pay the cost him or herself. In the residency program here, residents not only purchase their own lab coats but are responsible for their laundering as well.

Lab coats may be ordered on line at:

<https://cgibd.med.unc.edu/coreuse/orderlabcoats.php> (must use Internet Explorer 8, preferably FireFox). Questions can be addressed by calling 3-3946 or emailing cgibdweb@med.unc.edu.

Scrubs. If you need scrubs, please go to the area on the ground floor of the main hospital behind the Children's Hospital down the corridor beyond the Corner Café, near the Ultrasound Unit. There is a linen service where you can pick up sets of scrubs free of charge if you show your ID badge.

MEDICAL ILLUSTRATIONS

As of 5/1/07, Medical Illustrations officially closed and has absorbed into our Office of Information Systems (OIS) of our School of Medicine. Two staff members from Medical Illustrations have joined the staff at OIS and will perform a number of services that will continue to be made available to the SOM community, only now through OIS (063 MacNider). The following services have been combined with those services already provided by OIS:

- Computer design creation
- Digital imaging scanning
- Multimedia flash presentations
- Digital photography
- OR photography
- Video production
- Group photos
- Special events within normal working hours

OIS also provides printing of composite photos for each department. However, OIS does not offer the production of print materials such as passport photos, research posters, outdoor banners, or hot-press dry mounting. Fees for these services are in keeping with current OIS fees as posted on their web site, www.med.unc.edu/ois/facilities/multimedialab. Please contact OIS at 6-9900 with any questions you may have about any of these services.

CONFERENCE ROOMS

To reserve conference rooms, please notify the following individuals:

4100 Bioinformatics	Tiffany Eubanks	tiffany_eubanks@med.unc.edu	3-1072
	Jo Stevens	jo_stevens@med.unc.edu	3-3184
	Fern Jeremiah	fern_jeremiah@med.unc.edu	3-0758
4116 Bioinformatics	LaVerne Milliken	lmillike@med.unc.edu	6-6708
4146 Bioinformatics	LaVerne Milliken	lmillike@med.unc.edu	6-6708
4130 Bioinformatics	Nicholas Boyd	nicobb@med.unc.edu	6-2531
	Shirley Willard	shirley_willard@med.unc.edu	6-2531
4137 Bioinformatics	Melissa Lawrence	melissa_lawrence@med.unc.edu	3-0823
2127 Bioinformatics	KJ		3-0709
3127 Bioinformatics	Lynn Farrar	lynn_alston@med.unc.edu	6-9066
5127 Bioinformatics	Lauren		6-1343
	(Mondays call Ophthalmology)		6-5815

OR conference room 2 nd Fl Main Hospital	Stacey Owen	stacey_owen@med.unc.edu	6-4781
Women's Hospital Conference room 4 & WH room 60172	Lynda Dickes	LDickes@unch.unc.edu	3-0326
Cancer Hospital Conference room	Amanda Reynolds	areynold@unch.unc.edu	
Hospital Conference rooms	Patt Dower Windy Knight	PDower@unch.unc.edu WKnight@unch.unc.edu	
Bedtower Conference rooms	Cathy Wells (5 BT) April Schultz (7 BT)	aschultz@unch.unc.edu	6-7086 6-1517
1131 Bioinformatics, MBRB, & 4 th Floor Auditorium Old Clinic Building	Kenneth Perkins	kenneth_perkins@med.unc.edu	3-8884
4201 MBRB	Linda Miller	lcmiller@med.unc.edu	6-8946
5201 MBRB	Yvonne Cooper	yvonne_cooper@med.unc.edu	6-8555
7201 MBRB	Linda Miller	lcmiller@med.unc.edu	6-8946
3023 CTRC	Emily Leslie Powell		3-9536/6-1435 3-0267
3200 Thurston Bowles	Fran Spivak	spivak@email.unc.edu	6-0552
Computer Lab - West Wing of Old Infirmary Building	Craig Brown	CBrown@unch.unc.edu	3-0366
1007 and 2007 Medical Genetics		https://infoporte.unc.edu/reservations/room_list.php	
3007 MG	Lynn Ray	marsha_ray@med.unc.edu	
4007 MG	Arlene Sandoval	arlene_sandoval@med.unc.edu	
5007 MG	Cathy Cornett	catherine_cornett@med.unc.edu	

Please note that the OR conference room is reserved daily from 12 – 1 p.m. and Thursdays from 7:30 – 8:30 a.m. The 4th floor auditorium of the OCB (4008) is reserved Tuesdays from 4:30 – 5:30 p.m. (class) and each Thursday from 12 – 1 p.m. (Medicine Grand Rounds). 4137 Bioinformatics is reserved each Thursday from 4:30 – 6:15 p.m. for pulmonary clinical case conference.

NOTARY

If anyone needs any documents notarized, s/he may contact Fern Jeremiah (3-0758, Fern_Jeremiah@med.unc.edu) of our Division in 4160A Bioinformatics; Sherin Smetana (3-6386, smetana@med.unc.edu) of our Liver Program in 8015A Burnett-Womack, and Linda Miller (6-8946, lcmiller@med.unc.edu) of our IBD Center on the 7th floor (7200C) of MBRB. Lois Bender of the

Department of Medicine (3-6346, bender@med.unc.edu) has also notarized documents for us. Donna Wade (6-1072, dwade@unch.unc.edu) of our Graduate Medical Education Office is a notary, in addition to Michele Lowe (6-1216, mlowe@med.unc.edu) of our internal medicine residency program. In NC normally there is a \$5 charge per attestation of each document; however, our notary appointees do not charge for this service.

MEMBERSHIPS TO ORGANIZATIONS

Generally the fellow is responsible for paying his or her membership dues to organizations and subscriptions to journals unless otherwise indicated. Drug reps may agree to sponsor payment for such activities. Fellows are encouraged to join professional organizations. This year, we will pay for AGA and ASGE membership dues. A fellow may ask Dr. Fried of the Liver Program if enough funds are available to cover yearly AASLD membership. We do not cover ACG membership dues. The following is a summary of professional society dues for GI trainees: AASLD - \$90 annually; ACG - \$25 for the first year and \$195 thereafter; AGA – free for the first year and \$95 thereafter; ASGE - \$25 annually. For reimbursement for AGA and ASGE dues, fellows must submit original receipts, as they do with travel expenses. An original receipt may be printed from the web; if a check is written, the endorsed check must be submitted. Please remember for any receipts containing credit card numbers, if the full account number is displayed, blacken it out with heavy marker so it cannot be read.

AASLD

The American Association for the Study of Liver Disease (AASLD) offers trainee membership to fellows in an ACGME-accredited training program directly or indirectly related to hepatology; applications are accepted throughout the year. The applicant must provide an updated cv and a letter of recommendation by the fellowship program director.

The AASLD holds its annual meeting during the last week of October in Boston, with registration due by the latter part of September (9/25). Subspecialty residents should definitely sign up for the AASLD post-graduate course and can browse through the meeting website at www.aasld.org to see what else appeals to them. Per Dr. Fried, overall this is an excellent meeting with “no wrong choices” as to what sessions to attend.

The AASLD also provides funding for a hepatology fellowship, from which former fellows have benefited, in which case the fellow’s mentor must write a letter of support for the applicant (“A letter should be provided from the candidate’s mentor confirming his/her sponsorship of the applicant. Limit to one page.”). The mentor must also provide a clinical program description (“The applicant must include a detailed description of the curriculum, including weekly and monthly schedule of training and patient care responsibilities. Limit to five pages.”) In addition, the mentor must provide his or her AASLD membership number.

ACG

The American College of Gastroenterology (ACG) recognizes trainee membership of fellows in an ACGME-accredited training program directly related to gastroenterology. The applicant completes an application for trainee membership, approved by the ACG Credentials Committee. The fellow may remain in this category as long as s/he is involved in training in addition to one year following completion of training. The application fee is \$25.

The ACG hosts its annual conference yearly during the second weekend of October and provides a series of fellows' roundtable discussions, generally six different roundtable sessions covering three different topics presented by three of the field's experts. If a fellow plans to attend the ACG meeting and is interested in participating in one or more of these sessions, s/he may contact Christine Shukailo or Alicia Viglione at 973-971-0700 ext. 216 or fax the registration form to 973-971-0350, indicating the preferred session(s) and date(s). Ms. Shukailo's email address is cshukailo@cpeducate.com.

The ACG National Fellows' Forum takes place at the Gaylord Texan on Lake Grapevine in Grapevine, Texas each September. The forum invites training programs in gastroenterology and hepatology to nominate a fellow to present a clinical case or case series abstracts that illustrate unusual presentations of common GI diseases, or cases of rare GI conditions that demonstrate important diagnostic, therapeutic, or teaching points. The forum is sponsored by the ACG and supported by an educational grant from AstraZeneca. It is designed to provide an atmosphere in which fellows can exchange ideas with other trainees. The meeting format allows ample opportunity for interaction between trainees and experts.

Each nomination should include the subject matter of the case and, where possible, a two-to- three sentence description of the case. Thirty nominees are accepted. Once accepted, these 30 fellows are provided with support to attend the program and present their research to the experts. Ten of the abstracts are selected to be presented in podium format, and 20 abstracts are selected to be presented as posters. At the forum, the faculty evaluates all presentations and collectively selects the top three presenters. These top three presenters receive support to attend the 2008 Annual Meeting of the ACG. To be eligible for this award, the fellow must also submit the abstract to the ACG annual meeting.

In addition to the clinical cases and case series, the expert faculty provides "state-of-the-art" reviews on topics of interest to fellows. The scientific sessions begin on Friday afternoon and conclude with dinner that evening. On Saturday morning, the scientific program begins after breakfast and ends in the early afternoon. An awards banquet is planned for Saturday evening to announce the three winners. Departures are planned for Sunday morning.

This unique forum is both educational and enjoyable. Additional information can be obtained by contacting Elaine McCubbin at the ACG at (301) 263-9000 or emccubbin@acg.gi.org.

Each year, the ACG sponsors its GI Jeopardy Contest for GI programs across the nation. The competition consists of two stages: a preliminary program where all programs compete and a final round in which two-person teams from the top five scoring programs compete in front of a live audience in October at the annual ACG postgraduate course in Philadelphia. Travel expenses are covered by ACG for the five finalist teams. The preliminary round via on-line test generally begins on the Monday of mid July; deadline for completion of the preliminary round is usually on the Friday of mid August at 11:59 p.m. Each training program is issued its own password and uses it to log into the system at www.acg.gi.org/gijeopardy.

The test consists of 50 questions on a variety of GI diseases and organs. There is no limit to the number of trainees who may participate in this group answering the on-line questions, except two rules apply: only fellows-in-training may participate, and each training program's group is permitted to take the test only one time. Trainees may feel free to set up preparatory practice sessions.

A composite score is calculated for each training program, and finalists are selected based on the number of correct responses less a percentage of the incorrect responses, and additionally factoring in the completion time. Programs have the opportunity to complete part of the test and return to

do the rest without a time penalty; however, once a question appears on the screen, the clock begins to run.

The ACG Institute for Clinical Research & Education is proud of its track record of success in funding excellent clinical GI research and in investing in career development for young clinical GI investigators. The quality of the funded projects is consistently high. So many of ACG's funded researchers subsequently stay in research and academics, receive prestigious federal research funding, publish their findings, and present them at the ACG Annual Scientific meeting -- thereby enriching the scientific life of the College. ACG offers its Clinical Research Award, a one-time award of up to \$35,000.

In 2007, the ACG Institute awarded \$686,036 in support of clinical research in gastroenterology to 14 investigators, including three Junior Faculty Development Awards. In a separate RFA under the College's Colorectal Cancer Prevention Action Plan, ACG in 2007 funded two large one-time awards for projects relating to improving quality in colorectal cancer screening, bringing the total clinical GI research funding for 2007 to \$950,688. Since its inception, the ACG Institute has provided over \$8.2 million to 417 investigators. For questions regarding ACG's two awards, Clinical Research Award for fellows in training, or Young Faculty Development Award for junior faculty, direct inquiries to Anne-Louise Oliphant of the ACG staff: aloliphant@acg.gi.org, or 301-263-9000.

AGA

Fellows are invited to join AGA (American Gastroenterological Association) as a trainee member with the first year of membership free and \$95 the following year. Membership includes an online and print subscription to *Gastroenterology* (and Gastroenterology online), a print subscription to *Clinical Perspectives in Gastroenterology*, a print subscription to *AGA News*, and a print subscription to *Digestive Health & Nutrition Newsletter*. In addition, members are entitled to discounted registration to Digestive Disease Week, member discounts on AGA products, services, and educational offerings (including www.AGAPortal.org), access to the 'members-only' section on the AGA web site, membership certificate, and listing in the AGA Membership Directory. AGA sponsors a spring postgraduate course for two days in May, held in conjunction with DDW. This course is recommended for fellows because it presents the most updated information about emerging areas of gastroenterology and hepatology as they relate to a changing patient population. Topics covered include obesity and its effect on digestive health, gastrointestinal diseases in the elderly, latest advances in the diagnosis and therapy of GI cancer, Barrett's esophagus, liver disease, IBD, and motility. The course program can be viewed at www.gastro.org/spgc. To add the course to your DDW registration, go to online registration from the main registration page on www.ddw.org and click on "review or change your registration" (option 2).

Any resident, fellow or trainee who has completed at least two years of postdoctoral training in internal medicine or a closely related specialty area and who is continuing formal training in gastroenterology or any scientist, researcher or student with a post-baccalaureate degree who is pursuing a full-time postgraduate degree or program of study concentrating on gastroenterology is invited to join AGA as a trainee member.

Trainees and junior faculty are invited to attend the AGA Institute Academic Skills Workshop held in February. This unique workshop is designed to assist trainees and junior faculty in the field of gastroenterology to better understand the academic process and develop skills that will help them succeed in a highly competitive academic environment, including writing and obtaining grants,

delivering effective oral presentations, and preparing manuscripts. Funding opportunities are also reviewed. The workshop offers one-on-one mentoring sessions with experienced faculty. All participants are paired with a faculty mentor based on their research project and scheduled for individual mentoring. In addition, participants have an opportunity to meet with other faculty during the workshop to discuss their research. This informal workshop emphasizes attendee participation and close faculty/attendee interaction. There are ten plenary and breakout sessions in which faculty conduct various exercises, such as preparing and writing grants and clinical proposals. Candidates must be AGA members. Young scientists, MDs, MD/PhDs or PhDs with outstanding potential for careers in independent basic or translational science, clinical investigational research or training and education related to academic gastroenterology and hepatology are selected. Women and minority candidates are strongly encouraged to apply. A maximum of 60 individuals are selected. Each participant receives a scholarship, with meals provided. There is no registration fee. Interested parties are asked to complete a new electronic application at www.gastro.org, which they complete, save and upload with supporting materials, and submit via email. The application must include your name, cv (three pages maximum), letter of recommendation from the division chief or career mentor, personal statement (one-page outline of your short- and long-term career plans), and a grant outline, up to four pages, including specific aims, supporting background data, and specific experimental objectives. This may be for a basic science, clinical translational, outcomes or other study, but must include, at a minimum, a testable hypothesis, relevant background and proposed approach. Clinical educators may propose to address an unmet need in the area of training and education. Personal statement and letter of recommendation must be on separate, typed pages using one-inch margins, with an 11-point font. Completed workshop applications, including supporting materials, can be emailed to Cheyenne Hooker at the AGA Institute: chooker@gastro.org. Applications may also be mailed to her at the AGA Institute, 4930 Del Ray Avenue, Bethesda, MD 20814, ATTN: Cheyenne Hooker, or faxed to her attention at 301-652-3891. Applications are reviewed and selected by the workshop course directors and faculty, and participants are notified via email of their acceptance no later than mid-December. Last year, Dr. Sandler was a course instructor for this workshop, which three of our fellows attended. Feedback in regard to course content was extremely positive, the overall impression being that the workshop format was presented in such a way as to foster optimism and encourage trainees to seriously consider a career in academic medicine.

The Gastroenterology Research Group (GRG) of the AGA offered its 15th annual “Methodologies in Healthcare Outcomes in Gastroenterology: A Workshop Symposium,” on November 13-14, 2009 at the Crowne Plaza Beach Resort in Hollywood, FL, with the pre-registration deadline ending on October 30, 2009. The focus of this symposium is to improve one’s ability to design scientifically-sound clinical studies with direct applicability to clinical medicine by gaining hands-on experience in the design and implementation of outcomes research through

- participating in small-group sessions with expert faculty
- learning about real-life examples from current literature
- presenting planned or completed research as a case study
- taking part in an interactive poster session

To inquire about this symposium, email the GRG at marking@gastro.org.

A trainee member may also have the opportunity of serving on the AGA Training and Education Committee. This is a good way to network with other physicians and scientists while advancing the science and practice of gastroenterology. Interested individuals should contact Mark Donowitz, MD, AGA Vice President, AGA National Office, 4930 Del Ray Avenue, Bethesda, MD 20814.

Generally the individual is required to send a letter or an email expressing interest and why, along with an abbreviated cv of not more than six pages or a biosketch. Electronic submissions may be sent to msaval@gastro.org. The vice president considers applications for any open positions and nominates appointees. Nominations are then brought before the Governing Board for ratification at its annual November meeting. Appointees ratified in November begin serving a three-year term beginning in June. To receive an application, visit the AGA web site www.gastro.org. (Specifically, www.gastro.org/about/aga_membership_categories.html.)

For those who consider the pathway of becoming educators, in June 2012 AGA established an Academy of Educators. The mission of the AGA Academy of Educators is to be the home for educators within the AGA. The Academy is to be the pre-eminent forum to support and enhance teaching skills, mentorship, academic promotion, innovation, funding, career development, assessment skills, leadership, communication and scholarship. The Academy advocates for the education mission both as an academic priority and as a career pathway and recognizes excellence in education.

GOALS:

- Recognize and foster educational excellence, innovation, and scholarship throughout the career continuum.
- Provide resources for teaching, training educators, and leadership development.
- Develop strategies to obtain funding to support careers in education, including institutional and external support.
- Create a framework for documentation of educational excellence in support of promotion in an academic educator pathway.
- Advocate for the education mission both as an academic priority and as a career pathway.

AGA comes out with a yearly 'best of' conversations, available at www.gastro.org/conversations, and has recently launched its 'AGA GI Learn' website for trainees: <http://www.gilearn.org>.

ASGE

Fellows are invited to join ASGE (The American Society for Gastrointestinal Endoscopy) as a trainee member. A trainee member of ASGE enjoys the rights and privileges of active members, except the right to vote and to hold office. Annual dues for trainee members are \$25.00, which the fellow pays with the application, and include an online and print subscription to *Gastrointestinal Endoscopy*, a print subscription to the bi-monthly *ASGE News*, and a print subscription to the quarterly *ASGE Clinical Update*. In addition, members are entitled to free registration to Digestive Disease Week, practice guidelines and technology evaluations, access to the 'members-only' section of the ASGE web site, reduced registration fees for ASGE postgraduate courses, and access to awards and career development scholarships offered by ASGE.

Any resident, fellow or trainee who has completed at least two years of post-doctoral training and who is continuing in a full-time training status (which includes gastrointestinal endoscopy under the supervision of a member of the Society or an instructor whose endoscopic credentials are acceptable to the membership committee) is invited to join ASGE as a trainee member. The Secretary of the Society provides an application form that must be signed by the trainee's supervisor or instructor. A letter of recommendation from the supervisor or instructor authenticating the candidate's full-time training status (which must include gastrointestinal endoscopy) must be sent to the Secretary.

Trainee members can advance to active membership upon successful completion of endoscopic training. At the time training is completed, either a letter received from the trainee member's endoscopic instructor or chief of service, indicating successful completion of training, or a copy of the certificate awarded them, will accomplish the advancement to an active member of ASGE. Trainee members who advance to active membership immediately following completion of their training will enjoy no interruption in membership benefits and will not be subject to the \$100 initiation fee required of active member applicants but will be required to submit payment of \$100.00 annual dues as an active member. Trainees converting to active membership are given a 50% reduction in the first year's annual dues. To receive an application, visit the ASGE web site www.asge.org (Specifically, www.asge.org/gui/about/applications/benefits.asp#trainbenefits).

The fifth annual ASGE Workshop on Achieving Academic Success aims to provide participants an outline for a competitive research grant suitable for submission to ASGE or other funding organizations, such as NIH and VA. For this workshop, the target audience consists of ASGE members interested in developing success in grant writing, manuscript writing, and other key academic skills. Applicants are asked to provide a one-page statement of interest in the workshop; curriculum vitae; letters of reference from the division chief and program director or mentor (no more than two letters), and a one-page abstract outlining a specific research concept, including: hypothesis, specific aims, methodology, and rationale to be developed. There is no cost to attendees, as ASGE covers travel arrangements and associated expenses. Last year, the workshop took place on August 1 – 2, 2009, in Washington DC., and consisted of didactic group lectures as well as small-group breakout sessions in which participants presented specific protocols. The group then worked together to more fully develop these initiatives. Faculty members provided detailed critiques of each project presented. Topics covered during this particular workshop include: 1) how to pick a winning research project idea; 2) general principles of successful grant writing; 3) Foundation and Federal funding: what is available and how do I get funded?; 4) ASGE funding opportunities; 5) mentoring: when to select? how to select? who to select?; 5) how to succeed in academic GI: criteria for academic promotion; and 6) keys to successful manuscript writing. For more information regarding this workshop, please visit www.asge.org/grants, email grants@asge.org, or contact Jessica Oltman, ASGE assistant manager of Development, at 630-570-5625.

The ASGE Interactive Training & Technology Center (IT & T), a 3,000 square foot facility located near the ASGE headquarters outside of Chicago. This Center includes workstations employing *ex-vivo* animal models, one computer simulation workstation, and two capsule endoscopy workstations. Starting 2004, ASGE began to host three first-year fellow endoscopy courses at the IT & T Center. Complementing the hands-on section of the course is a full range of lectures and case discussions related to the endoscopic care and management of patients. The course program and curriculum have been standardized by the ASGE Training Committee. If you have any questions regarding the IT & T Center, please contact Dr. Christopher Gostout (gostout.christopher@mayo.edu) or Greg Paulos (gpaulos@asge.org), the ASGE professional educational officer.

The endoscopic training and education of fellows in gastroenterology programs is one of the primary goals of the ASGE. The ASGE Training Committee helps to fulfill this goal by developing a curriculum for endoscopic education, delineating guidelines for credentialing and privileging, and coordinating the highly successful First-Year Fellows' Endoscopy Course. Several of our fellows have attended this course and recommend it as essentially an invaluable educational experience for this important area of GI. All of our first-year clinical fellows are urged to attend this course, if possible. This course offers an excellent mix of didactic lectures and hands-on opportunities utilizing the ASGE IT & T Center. By 2006, a total of 300 GI fellows were trained. A set of nine core lectures and three video-based topics including "Introduction to Endoscopy," "Dilation,"

“Obscure GI Bleeding,” and “Foreign Body Management” have been designed especially for the first-year fellow. This is an ideal opportunity for trainees to participate in a standardized introduction to endoscopy and to meet/connect with their colleagues and regional experts in a relaxing, collegiate atmosphere. First-Year Fellows’ Endoscopy Course dates are generally set for each weekend in August. Course objectives include:

- Fundamentals of performing diagnostic upper and lower endoscopy, including principles of informed consent, procedure implications, biopsy techniques, and complications;
- Routine and special needs for successful sedation of the patient;
- Management of foreign bodies, including techniques for retrieval of ingested objects and indications for emergency endoscopy;
- Principles of electrocautery;
- Diagnosis and therapeutic techniques for managing acute upper and lower GI bleeding;
- The handling of endoscopies and endoscopic devices;
- Principles of feeding tube placement; and
- Infection control guidelines.

The ASGE Gastrointestinal Endoscopy Self-Assessment Program, 5th Edition (GESAP V) is a self-directed educational tool for new and experienced GI endoscopists that allows you to assess your knowledge of the appropriate use of endoscopy in the management of patients with digestive disease. GESAP V is intended to assess and improve your knowledge of important current topics in gastrointestinal endoscopy. Stay current on endoscopic topics with 200 questions with answers and critiques reviewed by experts in the field of gastrointestinal endoscopy. Chapters including Patient Preparation, Monitoring and Sedation; Esophagus; Stomach; Small Intestine; Colorectal; Pancreas; Biliary; Pediatrics; and Nutrition provide a thorough review of the field of gastrointestinal endoscopy – the perfect board exam study tool. At the conclusion of this self-assessment learning activity, participants should be able to:

- Understand new developments and important current issues in endoscopy;
- Apply knowledge of disease, clinical management strategies, and endoscopic technique; and
- Assess specific continuing education needs and identify areas in which additional study is needed.

For more information, visit <http://www.asge.org/nspages/education/learningcenter/gesapV.cfm>.

The ASGE site (www.asge.org) has been expanded to address educational aspects of endoscopy for trainees, including

- ASGE Community Outreach;
- Core Curriculum;
- GESAP Self-Assessment;
- DAVE Project;
- Video Editing Scholarship Program;
- Online Learning Center;
- Endoscopic Learning Library;
- Hands-On Training

QUARTERLY MEETINGS WITH DR. MADANICK

Dr. Ryan Madanick, fellowship program director, meets with all fellows on a quarterly basis to discuss fellowship issues. Dr. Madanick keeps an 'open door' policy for all fellows who need professional advice and career counseling.

BI-ANNUAL MEETING WITH MENTOR AND DR. MADANICK

Fellows are asked to meet with their respective mentors on a bi-annual basis (June and December) to discuss their research and overall progress. The mentor will notify either Dr. Madanick and/or Steve Kennedy of the outcome of this meeting. Once Dr. Madanick has this information, he asks that each fellow meet with him to discuss their progress and mid-year evaluations. Beforehand, they are asked to submit a self-evaluation of strengths and limitations and notate short- and long-term career goals so that we can try to match expectations. This bi-annual review meeting lasts about one-half hour. At this time, Dr. Madanick asks the fellows for any written abstracts for any national or regional meetings for inclusion in their files, in addition to any manuscripts or book chapters in press or ones accepted for publication or have been published within the year.

Faculty members also have a brief review of fellows' performance at our division faculty meetings twice a year, in June and December. This time is scheduled to discuss issues and develop constructive comments for the fellows, which are placed in their folders. At our yearly Faculty Retreat in early spring, one block of time is devoted to our fellowship program and implementation of any planned changes for the upcoming year.

In the fall of 2009, we developed an Education Working Group consisting of faculty members Drs. Doug Drossman, Jama Darling, Ian Grimm, Hans Herfarth, Ryan Madanick (program director), Scott Magness, and Steve Kennedy (program coordinator). As a training program, our goal is **to deliver superior education in gastrointestinal diseases and training in the investigation, practice and teaching of gastroenterology**. Strategies include:

1. To facilitate life-long understanding of gastroenterology;
2. To teach the process of taking care of patients with gastrointestinal problems;
3. To provide training in technical skills involved in gastroenterology;
4. To provide research training for the investigation of gastroenterology;
5. To train leaders in the field of gastroenterology;
6. To educate patients, providers and the public about gastroenterology.

ANNUAL RESIDENCY SURVEY

Residents are required to evaluate our program on an annual basis by going to <http://www.unch.unc.edu/SelectSurveyASP/TakeSurveyList.asp>, generally in October. Completion of this annual GMEC survey is important for continued approval of our program.

FELLOWS' EVALUATIONS OF PRECEPTING ATTENDINGS

The fellowship coordinator asks fellows to complete an on-line evaluation of attendings following rotations on a monthly basis. It is good for attendings to have evaluations by their fellows on file because administration reviews these as part of the process for determining promotions, e.g., from associate professor to full professor. Since the attendings evaluate the fellows on a monthly basis, the fellows are asked to do likewise. This information must be kept on file, not only as part of the attending's teaching portfolio required by the Department of Medicine, but for accreditation purposes as well. On 2/26/03, the Division Chief made it a requirement that all fellows complete such evaluations when asked to do so. Because of the issue of anonymity, the fellowship

coordinator altered the format of evaluations from hard copy to on line so that no handwriting can be recognized in the written comments section. Because of further concern for anonymity regarding the attending's ability to find out the identity of the fellow who has evaluated him or her right after the rotation, the coordinator has instituted a 'lag time'; additionally, attendings are not handed any evaluations—they are printed out and filed in their personnel file so we have documentation of this, which they can look over if interested. The site is <http://uncgihep.med.unc.edu>.

Additionally, because of the highly specialized nature of the endoscopy rotation, this year the fellowship coordinator has drawn up an evaluation that the fellows can complete for endoscopy attendings, located at the site above, in the same confidential manner.

During their time with us, fellows are asked to complete a **program evaluation** at the end of each year.

Attending evaluations of fellows. Per the same site above, attendings evaluate fellows on a monthly basis during their clinical rotations. As of 3/1/04, the fellowship coordinator solicits comments from ancillary staff members (i.e., nursing, secretarial) for inclusion in the fellow's personnel file, in addition to comments made by the coordinator, if deemed necessary. This is to provide an overview of the fellow's professionalism and behavior in differing levels of social context, both within and outside the clinical and procedural setting. Thus, we gain a composite from others in addition to input from the attendings. Per the ABIM, no fellow can receive unsatisfactory ratings in the clinical components of his evaluation during his senior year. The fellowship coordinator posts a composite of ABIM scores in the fellows' file during his or her final year.

Additionally, we have begun using procedural evaluations drawn up by the ASGE to evaluate for EGD, colonoscopy, and ERCP. These are excellent tools to evaluate individual procedural experiences and, we feel, a better means to elicit meaningful feedback. The endoscopy and biliary fellows are given PDF files that they can give to their attending after a rotation; the attending can fill out these forms and give them to the fellowship coordinator. Upon monthly notification for attendings to evaluate fellows, the coordinator reminds the endoscopy and biliary attendings to complete an appropriate ASGE form, which is attached to the notification.

The ACG CME Universe (www.acgcmeuniverse.org) contains learning modules based on our GI core curriculum. The program director can manage assignments and add content. Users can browse journal articles and abstracts. There is also a grant writing tutorial and self-assessment program.

ACLS

Our fellows are asked to continue their certification in Advanced Cardiac Life Support (ACLS). For recertification, fellows can contact our ACLS Office in room G-611 Neurosciences, phone 6-5629, fax 6-3049, pager 216-1093. The fee for this training is \$40.00, for which fellows receive reimbursement from our division. T. Steve Gardner, BHS, Paramedic for UNC Hospitals, is the program manager for Advanced Life Support at 1101 Weaver Dairy Road, Suite 104; phone 3-2030, email TGardner@unch.unc.edu.

TRAVEL FOR FELLOWS

Per Dr. Sandler on 6/24/03, the fellows' travel policy is as follows:

1. The division will provide \$1,000 for clinical fellows to attend a scientific meeting each year (funds are to be used for that particular year and do not carry over). Traditionally this has been the AASLD (American Association for the Study of Liver Diseases) meeting during the first year, DDW (Digestive Disease Week) during the second year, and ACG (American College of Gastroenterology) during the third year. The most important conference for fellow networking, outreach and exposure is the DDW conference: Over 14,000 medical professionals attend this conference, attracting worldwide members from the AGA, AASLD, and ASGE professional organizations. The web site address for DDW is <http://www.ddw.org>.
2. Research fellows (basic science, epidemiology) are provided \$1,000 per year to attend a conference. The epidemiology fellow generally attends the yearly EBM (evidence-based medicine) conference. Will Smith (6-3969, smith148@med.unc.edu) processes travel forms for those fellows being paid off of our CGIBD training grants and industry sponsorship. Research fellows paid from training grants are allotted \$2,000 in discretionary funds, which can be used towards the purchase of a standard laptop (\$1,125 with dock). We do not provide individual computers for clinical fellows, who are to use designated computers in their workroom at the hospital. Research fellows transitioning to clinical work usually bring their laptops to the hospital workroom, which helps free up computers for others to use. If a fellow does not wish to purchase a laptop (has his or her own), funds can be applied to other expenses, such as an additional conference. Training grants (and in some cases industry sponsorship) cover cost of tuition & fees and related textbooks. All expenses from training grants must be approved by Evan Ellis-Raymer, our grants administrator. Susan Thomas, our accounting director, can provide account numbers for those who wish to purchase textbooks directly at the bookstore. Please remember to keep these receipts and submit them for account reconciliation. If you have been at UNC for nine months or longer, please apply for in-state tuition if you plan to matriculate in our graduate school because the cost of out-of-state tuition is three times greater than in-state. Residing in our area for nine months or longer does not guarantee automatic in-state tuition. Rather, applying for in-state tuition is a formal process that the Graduate School must approve.
3. We have established a trust fund to support other fellow educational activities and have determined what can be drawn from this account (funds permitting). All expenses from this account must be approved by Dr. Madanick or Steve Kennedy. These include:
 - Lab coats (set of 2) at the start of fellowship;
 - AGA in-service training exam;
 - Trainee membership dues in two (2) of the four (4) national GI professional organizations: AGA, ASGE, ACG, AASLD;
 - ACLS recertification

Understand that we must be very judicious in terms of expenses coming from this account. Most texts are now online. Board review courses and independent studies are quite expensive. The program coordinator has assembled 2 volumes of board review materials, which fellows have borrowed among themselves, and which they have found useful. Linda Dalton (6-8559, ldalton@med.unc.edu) processes payments from our fellowship fund (Medical Foundation account).
4. Fellows have utilized other means to reduce expense such as obtaining industry sponsorship, using frequent flyers, sharing a hotel room, driving, or staying with a friend. For example, if a fellow is a member of the DDW Fellow's Reporter Program, this covers the registration fee, airfare, and a portion of hotel accommodations. Funds have also been used out of a mentor's trust fund account upon permission of the mentor and if funds permit.

A fellow may request a travel advance or wait until after the trip to request reimbursement. Travel advances are for airfare and conference registration only. Accounting prefers that airfare and registration be submitted in tandem to verify the request. If registration is free, documentation of the conference must be attached with airfare. We discourage doing travel advances because reimbursements must be done regardless post-travel, and, if the fellow is unable to attend ultimately, s/he would have to reimburse us. **Original** receipts are required, in particular for airfare and hotel expenses. If you have *charged* hotel expenses on a credit card, submit a copy of the credit card statement with your account number blacked out. *It is better to use your own credit card, rather than your spouses.* Often you must pay a partial amount in advance to hold a hotel room. Similarly, often payment must accompany registration. You may use airline e-ticket stubs as proof of purchase BUT NOT BOARDING PASSES. Other kinds of receipts include charges for cab fare, parking tolls at airports, public transportation to and from airports and hotels, airport shuttle service, registration fees, and abstract submission fees. If you are printing out receipts on line, make sure what you submit is the original print out and not a copy. If you wish to use a check as proof of payment, it must be a copy of the endorsed check or else a print out of the charge or copy of the endorsed check from your bank statement, either from on line or a hard copy.

Travel Accounting is reluctant to accept receipts if they are not the originals; however, if a receipt is lost and cannot be found, one can submit faxed copies with an explanation. For example, if one loses his hotel receipt, s/he can call the hotel and have this faxed. Travel Accounting usually calls about copies of receipts, especially if they pertain to hotel or airfare expenses unless they are charged to a personal credit card, for which then a copy of the statement suffices. The rule of thumb is to keep all (original) receipts for the trip in question. Receipts for food are not needed because of the per diem food allowance, as follows:

- Breakfast \$8.00 (both in-state and out-of-state)
- Lunch \$10.10 (both in-state and out-of-state)
- Dinner \$18.40 (in-state)
\$20.40 (out-of-state)

These figures include tips. If the cost of meals exceeds these amounts, the fellow must pay any amount over that. The fellowship coordinator or accounting personnel in CGIBD as well as the person who screens incoming forms in Travel Accounting make note of the time of day an individual left and returned to and from his or her trip in order to calculate the correct number of meals to reimburse. Please note that the per diem allowance is applied to those who are paid from grant or industry accounts. Clinical fellows paid from our fellowship fund (Medical Foundation) account can keep all food receipts, as the Foundation does not provide a per diem allowance and accepts individual food receipts. Food expense is intended for the fellow only, excluding bar. Hotel room rate includes occupancy/local tax only and not incidental expenses such as room service, restaurant, and bar. Internet connection fees may be covered if they are necessary for conference work. If two co-fellows share a room, each cannot claim reimbursement for the full room amount. Either two accounts must be set up for the room, or one can reimburse the other for his or her share. The invoice must have that fellow's name on it in order for that fellow to be reimbursed.

Often fellows wonder why they are not reimbursed for a breakfast or a dinner when they include the day as part of their travel reimbursement request. *This is because breakfast must be taken at the away location by 8:00 a.m., lunch 12:00 p.m., and dinner 6:00 p.m.* If a person leaves the away location at 6:00 a.m., no breakfast is to be counted for that day. If a person leaves at 11:00 a.m., no lunch is to be counted for that day. If a person leaves at 5:00 p.m., no dinner is to be counted that day. This includes breakfast, lunch, and dinner served on flights: meals served on flights are not counted as

meals to be reimbursed for that particular day, only meals taken within the time frame above at the away location. If a person travels to and from the conference destination by car, meals may be included during this travel time, but only as this travel time relates to the coming and going to and from the conference destination and not any other extraneous places. Sometimes individuals have incorporated vacation into and around a conference visit: we only reimburse for meals and for car mileage during that portion of the trip directly pertaining to the conference in question. Usually Travel Accounting reports changes in per-diem meal amounts in July of each year. Per diem food allowance is allotted regardless of whether or not there has been a hotel expense or if a meal is provided gratis as part of the conference. Reimbursement for hotel expense only pertains to the room itself + tax and no amenities such as phone calls, movies or videos, or bar, and is intended only for the fellow on conference leave, not spouse or other non-conference travelers.

Per-diem meals are reported *only for overnight stays*, which constitutes more than a 24-hour period (per the UNC Travel Office, "Allowances shall not be paid to an employee for meals if travel does not involve an overnight stay"). If a person is traveling in excess of 35 miles away from his or her destination, s/he can spend the night (this distance and beyond can necessitate a need for an overnight stay).

Receipts are also not required for gas expense if you travel by car, for which reimbursement is given @ 55 cents per mile. Per-diem rates for meals, lodging, and gas mileage increase every so often and are therefore subject to change; travel vouchers should be submitted with per-diem charges at the current rate. Usually Travel Accounting reports changes in per-diem gas mileage amounts in January of each year. If you are traveling to and from Raleigh-Durham airport and claiming this mileage for reimbursement, the mileage cannot exceed 18 miles one way, between Chapel Hill, as the work duty station, and RDU, or 36 miles round trip. **For trips exceeding 60 miles one way**, a State Car must be requested. If one is not requested, a person can only be reimbursed at 25 cents per mile. If one is requested but is not available, the person must write a statement of justification for this and will be reimbursed at the regular rate of 55 cents per mile.

In regard to rental cars, UNC Travel Accounting has strict guidelines on rental cars because car rentals cannot be for the convenience of the traveler. (Note this does not apply to those being paid from our Medical Foundation.) If you use a rental car, this use must be justified by submitting a signed, dated and explanation as to why a rental car is or was necessary. This is either approved or denied by Travel Accounting. A rental car is not to be used as an extension of one's educational conference, e.g., incorporating the trip as part of one's vacation, but only as it necessitates in relationship to the conference in question. An example of use of a rental car approved by Travel Accounting was when a fellow stayed with a friend near the conference and rented a car as transportation to and from the conference during the time it was held. The rental car turned out to be considerably cheaper than if the fellow had decided to stay in a room at the hotel where the conference was taking place. Gas mileage can be claimed as part of the expense associated with renting a car.

Individuals should be reimbursed only after having made a trip. There are cases in which a travel advancement is made to cover cost of conference registration fees, for example. However, if the individual fails to fulfill the anticipated travel, s/he must reimburse the account accordingly, as funds must be used towards actual travel related to training or work.

An employee who is traveling on UNC business for two or more consecutive days in a week is allowed one personal long distance telephone call for each two days, for which reimbursement to the employee may not exceed \$5.00 for each out-of-state call to the person's home. Any business-related calls made during the trip are reimbursable.

Travel Accounting now deposits reimbursements into a person's checking account in the bank (separate from pay deposits) instead of sending a check to the person's home address, unless that person is non-salaried, or that person is being reimbursed from our Medical Foundation. Travel Accounting is supposed to send a statement via electronic mail to the person, notifying him/her of this, so that s/he knows that money has been deposited into his/her account. A deposit may not necessarily be made in a lump sum, but rather money from each account number-object code or from some account numbers-object codes may be deposited separately, at different times. Travel Accounting can also screen an amount requested and not reimburse the initial amount requested for whatever reason(s). The fellow should make sure that his or her bank account has been reimbursed accordingly. We have had fellows whose accounts were reimbursed, and they were unaware of this. Conversely, we have had fellows whose accounts were never reimbursed, of which they were unaware. In this case, the fellow needs to notify the fellowship coordinator or the accounting personnel in CGIBD so that proper reimbursement is made. We do not know whether or not the fellow is reimbursed; it is the fellow's responsibility to keep track of this and to let us know if a reimbursement has not occurred or if there is a discrepancy in the amount of the reimbursement. Generally travel reimbursement checks are done within 30 days from the time UNC Travel Accounting or the Medical Foundation receives a request. If an individual is already in our system, the standard turnaround time should be 2-3 weeks.

Useful web sites for travel include:

www.indo.com/distance (How Far Is It? to find distances of locations)

www.google.com (search engine)

www.triangletcitysearch.com (Triangle City Search)

www.mapquest.com (directions to places)*

www.cheaptickets.com, www.agreatfare.com, www.expedia.com, www.jetblue.com,

www.orbitz.com, www.travelocity.com, www.usairways.com, (airfare)

www.priceline.com (hotel discounts)

www.weather.com (weather)

*It is recommended to use Rand McNally (www.randmcnally.com) because their maps are updated more regularly and tend to be more accurate than Mapquest; otherwise, www.googlemaps.com.

Any questions about a travel voucher and its content can be directed to Dawn S. Andres of UNC Travel Accounting at 3-5096 (phone) and 2-2356 (fax). The web site for UNC Travel Accounting is now integrated with Disbursement Services and can be found by going to <http://www.unc.edu/finance/mds/>, clicking on 'disbursement services' and scrolling down to 'travel', which contains various links.

Please remember to submit your request for travel reimbursement within the same fiscal year as the time of travel.

Military fellows are expected to comply with protocol as set forth by the Air Force or Navy in regard to travel expenses, in addition to expenses for textbooks and other related expenses. Generally in both respects their participation is justified as long as these opportunities are made available to all of our fellows as part of requirements for our training program. In some cases, the Military may cover expense itself. Any time away for conference leave should be cleared with military supervisors in advance.

MetLife offers a travel assistance advantage program through AXA Assistance USA, Inc. AXA is not affiliated with MetLife and is solely responsible for the services provided. The services provided are not part of the insurance coverage provided by MetLife. MetLife selected AXA to be the service provider for MetLife travel assistance services because they are an industry leader. Formed in 1959, AXA is best known for intervening in medical emergencies in foreign countries. In addition, AXA provides assistance services when a covered employee or dependent becomes ill or injured while traveling 100 miles or more away from home. AXA is a fully independent company and is not owned by or a subsidiary of MetLife. Call MetLife Travel Assistance when: 1) You are planning a trip and need general travel information; 2) You require medical assistance while traveling; 3) You lose documents, credit cards or luggage while traveling; 3) You require medical evacuation; and 4) You experience local language problems. If you are interested in this service, please call MetLife Travel Assistance at 800-454-3679 or 312-935-3783 (collect). AXA Assistance USA, Inc., is located on South Michigan Avenue, Suite 1100, Chicago, IL 60603.

CONFERENCES OF INTEREST TO FELLOWS

There are several outside conferences that may be of interest to our GI fellows. For example, the North American Conference of Gastroenterology Fellows (NACGF) is held this year at the Manchester Grand Hyatt in San Diego, CA, from April 12 – 15, 2007. The conference is sponsored by the American College of Gastroenterology and endorsed by the Canadian Association of Gastroenterology. The conference is supported by an educational grant from Procter & Gamble Pharmaceuticals. The program agenda includes research presentations by fellows, along with lectures, breakout sessions, and coaching by a distinguished faculty of gastroenterologists. The goals of the conference include providing fellows an opportunity to present their research to colleagues in a less pressured environment than at national meetings and to receive coaching on presentation skills from experienced faculty. Educational objectives for this part of the conference include the following:

- Design a poster presentation layout, or PowerPoint slide presentation, that clearly and appropriately illustrates the research project to the audience;
- Discuss orally a poster presentation, or a PowerPoint podium presentation, of research that clearly and concisely communicates the research project to the audience within a specified time limit.

Attendance at the conference is limited to forty fellows and is by invitation only. To contend for an invitation, fellows must submit an abstract of their research via the website, www.nacgf.org, which is open to receive abstracts from November 15, 2006 to December 31, 2006. A fellow may submit up to three abstracts. The research should be based on clinical or basic science gastroenterology and/or hepatology projects with which the fellow have been actively involved, including work in progress, work published within the past year, or case reports with comprehensive literature reviews. Fellows are selected competitively to receive invitations, based on their submitted abstracts. All fellows attending the conference are honored with a certificate of attendance. This is a three-day working conference, and each fellow's attendance is expected at all events. Three fellows attending the conference are selected to receive Distinguished Achievement Awards, which includes a \$1,000 travel award to the ACG Annual Meeting in October 2007.

The Educational Advisory Committee reviews all submitted abstracts and selects forty. In late January, the forty fellows submitting the selected abstracts will receive an invitation to attend the conference. The invitation includes information on whether the presentation is to be an oral PowerPoint presentation or a poster presentation. Details on the specific guidelines for the

presentations are included with the invitation, in addition to the general criteria by which the fellows are judged for the Distinguished Achievement Award.

Covered expenses for fellows attending the conference include hotel accommodations, group meals, round-trip coach airfare and transfer between the hotel and the San Diego airport. Spouses/guests are not included in the conference or at any conference activities, including meals. Spouses/guests may accompany the fellow on the trip at their own expense, however. Children and other family member and guests are discouraged from attending activities with the fellow unless absolutely necessary.

In the past, AstraZeneca sponsored its eighth annual (2003) 'Young Investigator's Conference in Digestive Diseases' at the Sheraton Wild Horse Hotel from April 10-13 in Phoenix, Arizona. This conference consisted of oral and poster presentations on upper GI, liver, biliary tract, pancreas, and lower GI. Again sponsored by the ASGE in cooperation with the AGA and AASLD and made possible by an unrestricted educational grant from AstraZeneca, the tenth annual conference took place in Washington, DC, from April 8-10, 2005.

This program offers young investigators in gastroenterology and hepatology the opportunity to submit abstracts of their basic science or clinical research to a group of world-renowned experts in the field. These experts choose 36 abstracts for formal presentation at the conference. 12 abstracts are chosen from the three areas: Upper GI (esophagus, stomach, duodenum); Lower GI (large and small intestine); liver-biliary tract-pancreas (including ERCP). If an abstract is accepted, it is presented in either oral or poster format. Educational grants of up to \$1000 to attend DDW are awarded to the top oral and poster presenters. For more information, contact MaryAnn McCluskey of Scientific Therapeutics Information, Inc., at 973-376-5655. Abstract forms can be downloaded from the ASGE website at http://www.asge.org/gui/events/young_abstracts.asp or from the Scientific Therapeutics Information's website at <http://www.stimedinfo.com/2125.htm>. One can also email abstracts@stimedinfo.com. Abstracts are due no later than January 4.

The ACG 11th annual Southern Region First-Year Fellows' Conference sponsored by AstraZeneca is held the first weekend of September in the Orlando, Florida, area. This is an excellent conference because it provides an overview of GI including the medical management of GERD and colitis, the diagnosis and treatment of complicated pancreatitis, H. pylori infection, hepatitis C, abnormal liver function tests, orientation to endoscopy, flexible sigmoidoscopy, colonoscopy, upper endoscopy and esophageal dilation, in addition to 'research 101'. Only first-year fellows from the Southeast region of the US are invited, including those research fellows moving into the clinical component of their fellowship program. Travel and hotel accommodations are provided, compliments of AstraZeneca. Business casual attire is appropriate for all functions. For questions regarding this conference, please contact Michelle A. McKee at Michelle.McKee@astrazeneca.com (cell 828-230-9624) or Heather Seasholtz of Creative Meeting Specialists, 877-267-0670, fax 215-996-0675.

Additionally, the ACG hosted its annual Second-Year Fellows' Conference from January 15 – 17, 2010, at the Hyatt Regency Grand Cypress in Orlando, FL. Fellow attendees have returned with extremely positive feedback on the usefulness of this conference as it contributes to their fund of GI knowledge. This course is quite popular with trainees and fills up quickly. This year offered breakout sessions on esophagitis, colon cancer screening, hepatitis B & C, pancreatitis, and GI radiology, with special sessions on IBD and therapeutic endoscopy. Each program throughout the US is to nominate one second-year fellow to attend this conference. This year, due to an overwhelming response to the call for nominations, committee members decided to increase the size of the course to allow participation by one fellow from each of the 116 programs that sent nominations. Ms. Maria T. Susano, vice president of membership & technology, is the contact

person for this event: phone 301-263-9000, fax 301-263-9025, email msusano@acg.gi.org, web www.acg.gi.org.

Of particular interest is the annual 'GI Fellows Conference' held during the last weekend of April in Myrtle Beach, SC, in conjunction with Duke University. In the past, Axcan and Merck Pharmaceuticals has sponsored this event; this year AstraZeneca is providing sponsorship. This conference has had an overwhelming positive feedback from those fellows of our program who have attended. There is no limit of the number of fellows from each program who can attend; in fact, increased attendance is encouraged, and a fellow who goes one year can go the next if s/he so desires and this is feasible in terms of finances and clinical obligations. This conference is designed for fellows of each GI fellowship program in the states of Virginia and North Carolina. Last year, Dr. Bozymski from our program was on the planning committee.

The purpose of the GI Fellows Conference is to provide an opportunity for fellows from diverse universities:

- To learn about research projects at each university;
- To present and discuss selected clinical cases;
- To gain presentation experience in anticipation of a similar presentation at a national meeting;
- To have a presentation critiqued by peers outside the fellow's own university;
- To hear lectures by GI faculty outside the fellows' university;
- To foster professional relationships with GI fellows from other universities.

Abstracts must be received no later than March 15. Abstracts must have scientific merit and must be the result of the work of the author. Abstracts are selected for oral presentation, and it is the planning committee's intent to invite all interested GI fellows to participate in the program; however, because of time constraints, only a specified number of presentations are allowed.

The presentation for a research project should last between ten and 15 minutes, with a maximum of five minutes of discussion following the presentation. The presentation for a clinical case or for a clinical case, diagnosis unknown, should last five to ten minutes, with a maximum of five minutes of discussion to follow. A PC laptop is available for Powerpoint presentation on CD-ROM.

Motel accommodations are reserved at a special rate. Lodging is provided through an educational grant to DUMC for all GI fellows who are selected to make presentations. Incidental expenses are the responsibility of each individual. Meals are provided for all participants; families are invited to attend the Saturday luncheon and dinner. For more information contact GI Fellows Conference, Dept. of Medicine, Division of Gastroenterology, DUMC, POB 3662, Durham, NC 27710. This year's faculty planner is Paul Jowell, MD, whose coordinator is Jodi Russell, email mjrusell@bellsouth.net, phone 919-308-1187, fax 919-681-8785.

The North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN) typically holds its annual conference during the fourth weekend in October, www.naspghan.org. As part of this meeting, fellows may attend a specially designed post-graduate course held beforehand. Past course topics have covered areas such as new insights into childhood functional abdominal pain and IBS: a multidisciplinary approach.

The Cedars-Sinai Medical Center's 'Annual Update in Gastroenterology' Conference is generally held the third weekend of October where an international panel of experts presents relevant

information on the diagnosis, pathophysiology and treatment of gastrointestinal disorders and liver diseases. Cedars-Sinai is nationally recognized in the areas of GI motility, IBD, hepatobiliary and pancreaticobiliary diseases. Speakers cover topics in the management of simple to complex issues in gastroenterology. Past educational objectives include:

- Apply new treatment options for patients presenting with GERD in addition to other complex esophageal disorders;
- Develop implementation strategies for the use of capsule endoscopy in the diagnosis and treatment of IBD;
- Evaluate trends in the treatment of IBD and the role research plays in the assessment of therapeutic agents;
- Review the latest advancements of EUS;
- Demonstrate appropriate medical management of obese patients undergoing gastrointestinal surgery and the impact minimally invasive surgery is having on the practice of gastroenterology;
- Practice the newest advancements in the diagnosis and treatment of GI motility disorders;
- Utilize the ever-changing, ever-improving treatments for viral-related liver diseases;
- Interpret new issues such as steatohepatitis and discuss liver diseases in the era of alternative medicine.

The facilitators of this conference determine its need based on the fact that gastroenterology is a rapidly evolving field. In the last year alone, numerous technological advancements have become better understood and utilized. Moreover, this is an age of enlightenment in the areas of IBD, hepatitis and IBS, and it can be difficult to keep pace with changes in these areas. For information regarding this conference, please contact Bari Laner at Cedars-Sinai Medical Center, 8700 Beverly Blvd., Atrium 119, Los Angeles, CA 90048; phone 310-423-5548, fax 310-423-0309; web site www.cedars-sinai.edu/cme.

The National Institutes of Health (NIH) and the National Medical Association (NMA) provided travel awards to residents and subspecialty residents in various programs throughout the country to attend the Annual Convention and Scientific Assembly of the NMA in New York, this year from July 23-28. The award covered expenses for transportation, hotel and meals for three days, from July 23-25. The intent of this award is to enhance the potential research careers of residents and subspecialty residents and to encourage research in disease areas that disproportionately impact the health of underserved communities. The NIH anticipates and hopes that, through this scientific opportunity, a greater number of physicians from communities underrepresented in science will enter into and remain in research positions. This opportunity is geared for basic scientists but also extends to those interested in clinical research. To be eligible, a trainee must meet the following criteria:

- Be an underrepresented resident or subspecialty resident;
- Submit a letter of intent describing his or her research interests and career ambitions;
- Include a current curriculum vitae;
- Submit a letter of support from the director of the training program of his or her division or department.

Underrepresented students include those other than Caucasian male. For more information, contact Frances E. Ferguson, M.D., M.P.H., Program Director of the Office of Minority Health Research

Coordination, NIH/NIDDK, Democracy Plaza, Room 644, 6707 Democracy Boulevard, Bethesda, MD 20892-5454; phone 301-594-9652; fax 301-594-9358; email FF54t@NIH.gov.

Other conferences include courses in gastroenterology and hepatology, designed for practicing clinicians who desire practical knowledge and recent discoveries relevant to patient care. The annual Mayo Clinic course provides a comprehensive review of issues in gastroenterology, hepatology and endoscopy with a focus on new/emerging medical therapies, innovative techniques, breaking developments and challenging cases. Upon completion of this course, participants should be able to:

- Assess for complications and manage medical therapy in patients with chronic viral hepatitis.
- Evaluate patients with hepatic cirrhosis for complications such as portal hypertension, ascites, encephalopathy, and hepatocellular carcinoma.
- Manage patients with miscellaneous gastrointestinal disorders such microscopic colitis, celiac disease, occult gastrointestinal bleeding, and autoimmune pancreatitis.
- Integrate techniques learned from live endoscopy sessions.
- Assess gastrointestinal symptoms in patients with obesity, including those who have undergone bariatric surgery.
- Assess disease activity and prescribe appropriate therapy, including immunosuppressives and biological agents, to patients with inflammatory bowel disease.

For information and registration, visit <http://www.mayo.edu/cme>.

Johns Hopkins presents an annual course in gastroenterology and hepatology in March. Past courses have covered gastrointestinal bleeding, colonic diseases, digestive health in women, liver disease, inflammatory bowel disease, pancreaticobiliary disease, state-of-the-art endoscopic intervention (including an endoscopic nursing workshop), and challenges in the clinical practice setting. For information and registration, visit <http://www.hopkins-gi.org>.

Requirements of Clinical GI Fellows

All fellows during the course of their enrollment in our fellowship program are expected to attend a composite of 85% of the required conferences described below, with attendance taken. To sit for boards, one needs a three-year fellowship, of which 18 months is clinical. A fellow's continuity clinic of three years can count each as one month, or three months applied to the 18 months, leaving 15 months for clinical rotations. This clinical work must be done at and supervised by attendings of UNC Gastroenterology and Hepatology. A research fellow doing four years in our program would therefore have to start some type of clinical work during his or her second year in order to sit for boards at the appropriate time. This is also per ABIM guidelines. In addition, we try to tailor the program so that at least 30% of clinical exposure falls within the realm of hepatology. This equates into five months. Fellows should actually surpass this by a) their hepatology rotations; b) rotations through hepatitis and liver transplant specialty clinics; and c) liver patients seen as part of their general patient caseload in their continuity clinics.

Additionally, for successful completion of our program, a fellow must present with a final research project and have complied with the necessary number of procedures as determined by the ASGE. Final evaluations are completed on each graduating fellow.

Fellows are **required** to attend the following as part of their educational experience with our program:

- GI Grand Rounds, known as the “GI Medicine Conference” or “Clinical Case Conference,” held each Tuesday from 4:30 p.m. to 5:30 p.m. in the O.R. Classroom on the second floor of the main hospital. This conference is our most important conference for teaching and patient care. As of March 2003, two fellows are assigned each week to bring an outpatient case for presentation. Please do not be inconsiderate to the clinic fellow by not preparing a case when it is your turn. This conference is now ongoing throughout the year, with the exception of the session during DDW. In terms of CME sponsorship, Dr. Nuzum serves as the course director. However, Dr. Madanick has assumed responsibility from Dr. Shaheen in drawing up the yearly schedule and assigning one attending each week to present a case. Fellows volunteer to draw up their portion of the schedule. Previously, Jon Hansen assumed this responsibility; this past year, Brock Miller. With the format of three cases presented at each meeting (2 by fellows and 1 by an attending), allocation of time – including questions, brief discussion, and suggestions or recommendations for each case presented – should average 15-20 minutes per case to stay within the designated hour, such that our GI medicine-surgery conference, which follows, can start on time. This means that the presentations themselves should be 10-15 minutes maximum, to allow for 5-10 minutes of discussion/Q & A. Because there are three people giving talks on any assigned day, please do not exceed your allotted time. Presentations should be case-based. The case itself should exemplify a focused question, with 1-2 teaching points. Ideally the case should be followed by a short series of questions (2 or 3) that can be answered through a search of the literature. You do not have to review the entire disease process, and not every article has to be presented. It might be better to leave some out and prepare ‘backup’ slides for responses to anticipated questions. Special speakers may speak for an hour, but generally should speak for 45-50 minutes (or even less) to leave enough time for questions and discussion.

It is important to remember that, because this is a CME-sponsored activity, we cannot schedule a CME-sponsored outside speaker on the same day or time unless we cancel credit for that particular session or else have a special presentation outside of this time. Food is not allowed in this space. Per CME guidelines, this activity day and time are to remain fixed, and in this location. The fellowship coordinator should be notified of cancellations in advance so he can send out a blanket notice and let our UNC CME liaison know.

In the past, there have been many requests from educational companies who have asked that CME-sponsored speakers present at our Grand Rounds. In this respect, we must avoid a potential conflict of interest. Additionally, so that educational presentations are not masked as product promotionals, Dr. Sandler should screen such requests. If an attending invites a guest speaker, that speaker must complete paperwork per CME protocol. In this case, the host attending is responsible for that speaker’s visit. We do not provide honorariums for such speakers. Instead, this would have to be provided somehow by the host if such an arrangement is agreed upon.

This conference gives us the opportunity to review and teach using interesting and challenging cases of the week (seen by consult or in clinic) with the entire GI division and outside physicians. The learning objectives include 1) delineate the principles of gastroenterology and hepatology as illustrated by each week’s most instructive patients seen in UNC-Hospitals and clinics; 2) describe the changing methods and therapies applied in the UNC setting; 3) develop a habit of critical thinking through active discussion between trainees and faculty colleagues; 4) provide feedback to individual practices and groups. The following are some helpful hints to “running” a good conference:

- a) Begin considering patients to present early in the week. By Tuesday, 5-7 cases should be available, knowing that not all will be presented. The “MC” or host of the conference is the consult attending. If the consult attending cannot come, s/he must find a replacement.
- b) The clinic fellow is the primary coordinator of the conference. Presenters will discuss the cases they plan to present with the clinic fellow on the Friday prior to the Tuesday presentation to allow for the presentation of any histology that goes along with the case and to avoid overlap with other planned cases.
- c) The Pediatric GI, Adult GI, Liver, and Endoscopy teams should be asked if they have a good case to present. Cases are contributed from the following sources: GI consult team (one inpatient case), liver consults (one inpatient or outpatient case), and two assigned fellows (one outpatient case assigned per fellow). The assigned fellows should prepare cases from the outpatient specialty clinics (Esophageal, Functional Bowel, IBD, Liver, Motility, Pancreaticobiliary) or may present a case from their own continuity clinic population. The cases presented by the two assigned fellows should be patients who have already been worked up so that the final clinical impression and follow up are available.
- d) Each conference should include four case presentations by the fellow, resident, or study of information garnered from the literature relevant to cases presented. A case presentation should not take any more than ten minutes. If the case is long or complicated, provide a case summary handout or make an overhead display. A handout or paper highlighting important points is useful. Handouts should be distributed following a case presentation. A short formal presentation should accompany the case with “take home” points and a brief bibliography. The topic discussed should be well-circumscribed; for example, do not discuss ‘variceal bleeding’ in a broad sense. Rather, discuss a related topic in a more specific sense, such as discussing the use of detachable snares for actively bleeding fundal varices. It is impossible to cover the former topic in ten minutes, but feasible to cover the latter.
- e) After the initial presentation, the consult attending should elicit a working differential from a fellow in the audience. The physical and initial labs should then be given, followed by a reordering of the differential by the fellow.
- f) After the presentation is completed, a brief discussion of the problem illustrated by the case may be offered by the presenter or another member of the presenting team. If a student or intern is to do this discussion, it should be screened before the meeting by the consult or liver fellow to assure that its tone and content are appropriate for the meeting.
- g) At least once during a four-week elective, a student should be asked to present a brief report on a subject related to his/her patient, including preparing a one-page handout. This should be assigned by noon on Friday.
- h) For patients with pathology, their name and unit numbers should be given to the GI pathology resident by the preceding Thursday, no later than 2:30 p.m. Pathology cases should be early in the conference, if at all possible.
- i) A list of x-rays needed for the conference should be given to Film Assembly by 9 a.m. Monday. Get the x-rays by 2:00 p.m. and select the films to be shown before 2:30 p.m. For ‘unknown’ x-rays, you may want to call on faculty or senior fellows.

- j) Every effort should be made to obtain all pertinent films and pathology for the case presentation of the work up and hospital course.
- k) Present morbidity items (e.g., side effects of a procedure) once a month, usually the first Tuesday of each month as part of the Morbidity and Mortality (M & M) Conference. The Risk Management (Legal) Office of the hospital keeps a record of all reported complications. Write down what we decide as a remedy for the problem and give to the Medical Director of the Procedures Area, Dr. Grimm, or to Dr. Nuzum, coordinator for CQI (Continued Quality Improvement), to include in our quality assurance report.
- l) Please turn in any material that needs to be typed up into a handout to the GI consult attending's secretary by 10:00 a.m. on Thursday to be ready for pick up by 1:00 p.m. on Monday. Include your name and date of conference on this handout. Please include your phone number or beeper number with the material.
- m) 90+% of GI practice is outpatient medicine. Thus, the tendency of this conference is to over-emphasize inpatient problems since these are the complex patients seen on our consult service.

To make this conference more stimulating, you can be creative by bringing a patient to conference or using a TV video of endoscopy. Try to avoid a subject presentation after 5:25 p.m. because we need to start the GI Surgery Conference on time (5:30-6:00 p.m.).

As of 12/4/03, because fellows have requested that this conference would be improved with increased participation from the faculty, it was suggested that faculty members take turns presenting a case at this conference, one each week. This seems reasonable and improves the educational experience for fellows and faculty alike. To this end, Dr. Sandler periodically asks to review faculty attendance. Each week, a faculty member is assigned to bring a case to discuss informally. If a faculty member is unavailable for the week assigned to him or her, s/he may switch with someone else on the list. If a faculty member is not out of town and does not have any conflicts in his or her schedule, s/he is expected to attend and participate in this conference. It is expected that everyone be on time for this conference and that it start and end on time so that the GI Surgery Conference can start on time as expected. As of 5/7/09, attendance at the GI surgery conference is required of our fellows to broaden and enhance their exposure to the various dimensions comprising the field of gastroenterology.

- GI Surgery Conference is held each Tuesday from 5:30 p.m. to 6:00 p.m. in the O.R. classroom on the second floor of the main hospital, following the GI Medicine Conference. Dr. Tim Sadiq (tim_sadiq@med.unc.edu, 6-8436) assigns surgeon speakers. Dr. Madanick assigns attending dates to speak by their affiliation with a Center, and a select fellow assigns co-fellows. Each fellow and attending should therefore only have to present once. If a fellow cannot present on his or her assigned date, s/he can switch with another fellow. Attendings can switch with another attending, as long as the presenter with which the switch is made is speaking on the same general topic (e.g., liver switches with liver; IBD switches with IBD, etc.). It is unacceptable for anyone to be unprepared when their date comes up. Attendings are encouraged to be prepared and responsible in this regard to enhance the teaching-learning experience. On 10/23/09, Dr. Madanick drew up conference objectives:
 - a) to understand the evaluation and management strategies of gastrointestinal disorders that have surgical management options; b) to recognize the indications, contraindications, and alternatives to common gastrointestinal surgeries; and c) to appreciate difficult situations and controversial

issues about gastrointestinal disorders that have surgical management options. The goal of this conference is to provide an educational experience for GI medical and surgical attendings, residents and fellows to discuss topics of common interest to both groups and should consist of a 15-20 minute case-based discussion, followed by 10-15 minutes of Q & A. The presenter should create 3-5 educational objectives. At the beginning of the talk, the presenter should present an actual case that is representative of the topic for discussion. Additional case-based information (e.g., a case summary or additional studies) can be presented throughout the remainder of the talk. Each presenter should submit the title of the talk at least one week prior to the session to the GI fellowship program coordinator and, following the conference, should submit his or her presentation to the coordinator for archiving.

- Morbidity and Mortality (M & M) Conference, held the first Tuesday of each month as part of the GI Medicine Conference, limited to the first half hour. (Surplus cases can be reviewed at the next M & M session, given overall variability in number of cases presented per session.) The M & M Conference is a tool to help care providers get into the habit of reviewing suboptimal outcomes for improved management of patient care and to reduce and minimize risk recurrences as a way towards continuous improvement in the quality of our service and the safety and satisfaction of our patients. Since we no longer have our inpatient Med A service, our conference now focuses on morbidity (complications of procedures etc.) as opposed to mortality (death). Morbidity forms may be obtained from the fellowship program coordinator. These forms must be completed at the top prior to the conference and at the bottom after discussion, before leaving the conference. Any complications occurring during the previous month must be reported and discussed at this meeting. We have also had special half-hour presentations.

Continuing its superiority in the risk management field, The Risk Management Handbook for Health Care Organizations (5th Edition) is written by key practitioners and consultants in the field. Included are practical and user-friendly chapters and health care examples on methods and techniques of risk reduction and management as well as operational and organizational models. Up-to-date explanations of regulatory and legal changes can help novice and veteran risk managers learn to manage risk effectively. The role of the risk manager in patient safety is a common underlying theme, with a focus on the operational risk inherent in all healthcare organizations, with particular emphasis on clinical risk. For information on obtaining this comprehensive handbook, contact Amy Cole, Senior Manager of Research and Markets Ltd., amy.cole@researchandmarkets.com.

- Journal Club, held on the first Monday of each month (now ongoing throughout the year) from 5:15 p.m. to 7:15 p.m. in 4137 Bioinformatics. This past year, Brock Miller drew up our schedule (fellows' portion) in conjunction with Dr. Madanick (attendings' portion). The goal of Journal Club is to review current major articles/topics related to GI and to foster a sense of critical awareness in appraising the literature as it relates to medical decision making. Individuals can send their articles to Dr. David Frantz for posting on our fellows' resource site at www.unc.edu/~dfrantz. The fellowship program coordinator can disseminate articles to clinical faculty members and other fellows. The coordinator keeps a file of previously presented Journal Club articles as a resource reference. If the host wishes to alter a session (generally move it back a Monday or two), the coordinator must know so that he can send notification to this effect. Once the schedule is finalized, presenters are responsible for switching among themselves and are asked to notify the program coordinator to this effect. If posted or disseminated, articles can be reviewed and discussed prior to each meeting. One of the two fellow presenters should set up for monthly Journal Club. If one of you is not on service, if you can, please try to come early and set up.

Articles for Journal Club are selected by the fellows who are presenting and given to the faculty host for approval *no less than two weeks* before the date of the Journal Club. The host will approve the articles (one primary article and one secondary) or work with the fellows to select others if s/he deems the selected ones are not appropriate. The host and fellows are then responsible for making sure that the chosen articles are posted to our fellows' resource site. Criteria for selection should be of high quality of the research and analysis with findings that are clinically significant or make a difference in a research field.

Journal Club Rules state that Journal Club will be divided into two one-hour segments, the 'in-depth' review, and the 'lightning round'. The in-depth review will consist of review and critique of current literature, with an emphasis on critical appraisal and study quality. The 'lightning round' will be a brief synopsis of the GI literature from the previous month, with an emphasis on 'take-home points,' and a minimal critique.

The In-depth Review

- Journal Club will start promptly at 5:15 p.m.
- The attending host and each of the two fellows will present up to two papers each (six total) during this segment. It is acceptable to present one paper. Papers should be from within the last six months.
- These papers will be chosen by the attending host and the participating fellows jointly and may, should an attending wish it, conform to a theme such as IBD, motility, esophagus, liver, etc. If a "theme night" is chosen, papers should still be from within the last six months.
- Not less than two weeks prior to the assigned Journal Club, the fellows will confer with the host attending to decide upon appropriate articles.
- Generally, the articles will be presented in ten-minute slots. The first five of the ten minutes will be a brief explication of the article by the presenter, concentrating on a synopsis of the article with a brief discussion of the article's strengths and weaknesses. Formal criteria for critiquing articles, such as the McMaster criteria, may be useful for organizing your thoughts; however, it is unlikely that both a review of the article and a point-by-point critique of the article describing all of the criteria can be accomplished in five minutes, and so this is not recommended. In general, do not concentrate on minutiae. If you adhere to the main goals, study design, stated outcomes and results, you should have enough time to cover the article and discuss its strengths and weaknesses.
- The second five minutes of the ten-minute block are reserved for open discussion of the paper. During this period, individuals who work in the area discussed by the paper will help the group put the paper in the greater context of the field.
- At the end of the second five-minute segment, we will continue on to the next presentation.
- After the six presentations are completed, we will move on to the 'lightning round'.

The Lightning Round

- The goal of the lightning round is to provide a brief synopsis of interesting papers in a wide variety of journals. Unlike the 'in-depth' portion of the Journal Club, the focus here is on *informing* (what?), rather than critiquing (how and why?).
- The presenters will divide the major journals in which GI materials appear, including Gastroenterology, Gut, American Journal of Gastroenterology, Hepatology, New England

Journal of Medicine, Lancet, Transplantation, Annals of Internal Medicine, Digestive Disease Science, Clinical Gastroenterology.

- The presenters will take turns doing a two-minute presentation of papers of interest in the journals they have chosen. The goal in these two minutes is to make statements of the work, such as “What was the question?” “What was the study design?” “What are the results?” “What were the conclusions?” If the presenter wishes, s/he can offer one or two major critiques; however, again this is not the focus of the lightning round.
- In the last three minutes, other attendees may comment on the importance of the paper and offer any other thoughts or critiques about the papers.
- The goal is to cover at least 12 papers (four per presenter) in the lightning round.
- The Journal Club will end promptly at 7:15 p.m.

Hints for a successful Journal Club presentation:

- A couple of sentences to set the study in context are generally all that are necessary. It is not necessary to start with, “Hepatitis B is a major cause of liver-related mortality world-wide.”
- Use of the table or figure that describes the main result from the paper itself is often helpful to get your point across.
- Calculation of commonly used clinical epidemiology stats such as number needed to treat, absolute difference, attributable risk, and other data when appropriate often helps your audience to understand the impact of the data.
- Einstein could explain the theory of relativity on a single sheet of paper. You should be able to tell us salient points in a concise manner.

These Journal Club rules were agreed upon by our faculty at our annual division faculty retreat in 2/03.

We expect faculty to make every effort to attend. More importantly, if you are the faculty member assigned to Journal Club, you should do the following (9/14/10):

1. Help the fellows pick an acceptable paper. The paper should have strong methods and should change our understanding of a disease or our approach to management. A case report or case series is not good enough.
2. Set a good example. Since we abandoned paper, the standard is a few PowerPoint slides that summarize the methods and show the tables or graphs. The slides should be readable.
3. The Journal Club format is supposed to be patterned on the ACP Journal Club where the paper is summarized in 300 words. You do not have to stick to 300 words, but the description of the study must be brief enough to permit critical appraisal and discussion.
4. The faculty member assigned to Journal Club should moderate the session and make sure that we move things along.
5. Encourage presenters to get there early and load their presentations ahead of time so we do not spend a lot of time loading and hunting for presentations.

Per above, fellows should do the following:

- You should select your papers based on their methods and importance. They should have strong methods and change our understanding of a disease or our approach to management. A case report or case series does not suffice.

- Your selected papers should be discussed ahead of time with the faculty member assigned to host the monthly meeting.
 - Your presentations should be in a few PowerPoint slides that summarize the methods and show the tables or graphs. The slides should be readable. It should be brief (5-7 minutes) and allow time for commentary from the attendees.
 - The Journal Club format is supposed to be patterned on the ACP Journal Club, where the paper is summarized in 300 words. It is not necessary to adhere strictly to 300 words, but the description of the study must be brief enough to permit critical appraisal and discussion.
 - When you are presenting, try to be there early so that presentations can be loaded ahead of time.
- The Pathophysiology (Core Curriculum) Conference is held each Wednesday from 7:30 a.m. to 8:30 a.m. in 4137 Bioinformatics July through June of each year. Traditionally goals have included 1) explain pathophysiology as it relates to the particular organ system/disease process in gastroenterology and 2) describe the clinical correlation of the organ system/disease process. However, on 8/23/10 our Educational Oversight Committee agreed to modify and expand conference goals as follows:
 - To understand normal development, anatomy, and physiology of the GI tract;
 - To understand general pathophysiologic concepts germane to gastrointestinal disorders;
 - To understand the specific pathophysiologic mechanisms, epidemiology, diagnostic strategies and management of disorders of the GI tract;
 - To understand diagnostic modalities, their rationale, and their strengths and limitations, available for GI tract disorders.

Within the hour, the forum consists of a 45-50 minute presentation, followed by 10-15 minutes of discussion, but may consist of a shorter presentation with discussion taking place during and after the presentation. A more realistic distribution of time would be 40:20. The goal of this conference is to present GI-related topics covering all of the major areas of GI and hepatology over the three-year cycle for clinical fellows. This constitutes our core lecture and curriculum series and helps prepare our fellows to sit for boards, with an eye toward what they also need to know for general practice. Topics are drawn from the AGA core curriculum and are assigned to both faculty members and fellows, who are asked to present one lecture. We also encourage a mentoring session for a topic assigned to a fellow with which a faculty member can assist the fellow and be present with him or her at the conference. Faculty members have been asked to increase participation in this important teaching and learning educational forum for our fellows, which should constitute protected time. The end result of this forum is important, since the time the fellow spends in preparing as well as giving presentations is part of the overall learning (and teaching) experience for him or her. The clinic fellow is responsible for setting up this conference; however, fellows housed in Bioinformatics can assist as well.

- Research Seminar Series (GI Research Conference), held each Thursday from 4:30 p.m. to 5:30 p.m. in 1131 Bioinformatics Building from August through May. Per Dr. Sandler's directive, no fellow is to miss this seminar without a valid reason. Fellows must attend this conference to fulfill board requirements for successful completion of our program. If a fellow cannot attend, s/he is to notify the fellowship program coordinator. Dr. Scott Magness (magness@med.unc.edu) arranges our research seminar schedule. Given that audience members are clinicians as well as basic scientists, speakers are urged to designate

clinical implications of their research for our MD fellows. The audience at this conference is quite diverse, including faculty, postdocs, GI fellows, and students. Dr. Balfour Sartor has suggested that recent trainees (both MD and PhD) on our basic science training grant be included as speakers in this seminar series. This grant has supported a number of talented and highly productive scientists who have produced interesting results that could be of general interest to our combined faculty and fellows. The training grant committee strongly recommends that each trainee present their research following or near the end of their period of grant support so that presentations are polished and comprehensive. The goal is two-fold: 1) to provide experience to trainees in presenting their work to a friendly but informed audience and 2) to further solidify the research emphasis of our fellowship program. To this end, we wish to create an environment in which expectations for scholarship are high for our trainees and to demonstrate to both the junior fellows and our faculty the quality of research attained by our trainees. We believe that success by our recent trainees will foster success in current trainees and stimulate those fellows not currently active in research to take advantage of our research resources during their fellowship to produce scholarly work.

- On Thursday, 6/25/09, members of the Division met as a Task Force to review objectives for our required conferences. This committee included Dr. Ryan Madanick, Steve Kennedy, Sid Barritt, Seth Crockett, Lisa Gangarosa, and Joanna Herath. On 9/2/09, Dr. Madanick determined that the Drossman Teaching Conference (Functional GI Disorders Clinical Discussion Group), this past year organized by Dr. David Frantz, and generally held the second or third Wednesday of each month from 5:00 p.m. to 7:00 p.m. in various hospital locations (by announcement, but often held in conference room 3023 in our Clinical Trials Research Center or CTRC on the third floor of the main hospital), should be a required conference. Given that 1/3 of patients in a GI clinical setting can now present with FGID and related conditions, our fellows should be prepared to treat and effectively manage this challenging caseload. In the past, this didactic session has involved handouts on treatment approaches for IBS, personality types of the IBS patient caseload, observation of and comment on mock interviews and role playing between attendees playing the part of physicians and patients, actual patient presentations, and the viewing of videos created by Dr. Drossman and colleagues in which they pose as physician and patient as a way to represent the pros and cons of the patient-physician relationship and how the physician can become more effective as a listener and in discerning communication through an individual's body or non-verbal language, which can be as important, if not more important, as dialogue itself. This is an extremely useful learning experience for those physicians who expect or plan to work with IBS patients. Generally the fellow who coordinates this activity does so for two years.

Attendance is taken at required conferences. Fellows are urged to notify the program coordinator of reason for absence so that this can be notated accordingly. Our Division Chief reviews attendance sheets periodically. Once final schedules are sent out, fellow presenters are responsible for making switches among themselves and notifying the coordinator to this effect so that these changes can be made to the master schedule.

Presentational Skills: In order to gauge time appropriately, the presenter should factor in one slide per minute. Pathophysiology should consist of a 45-minute presentation, followed by 15 minutes of a Q & A session. GI Grand Rounds should consist of a 10-15 minute presentation of a focused question. It is better to have a shorter slide presentation, allowing for more post-questions, than multiple slides followed by little discussion. GI Medicine-Surgery should consist of a 20-minute presentation, followed by case discussion.

It is *highly recommended* that fellows attend weekly Medicine Grand Rounds, held each Thursday from 12:00 noon to 1:00 p.m. in the fourth floor clinic auditorium of the Old Clinic Building (lunch provided). Certain Grand Round dates are represented by faculty of each specialty Center of our division. Our faculty decided that 50% of our Grand Round speakers should be local or homegrown, with the other 50% being outside speakers. Two faculty members from each Center line up the content. Anyone not working in one of our Centers but desires to speak or invite an outside speaker can arrange with the appropriate people and ask if you can borrow their slot for the year. You need to indicate at least three months in advance the speaker and title of talk.

Fellows have the option of attending our Pelvic Floor Disorders Conference held the third Wednesday of each month from 7:30 a.m. to 8:30 a.m. in 4002 Old Clinic Building (Urogynecology Conference Room). This is an interdisciplinary conference during which motility cases are discussed with the input of clinicians from OB-GYN, radiology, urogynecology, and surgery. Cases are to be submitted to Denise Coleman (6-0005), denise_coleman@med.unc.edu, no later than the Monday prior to each Wednesday meeting. Please include the patient's name, medical record number, and diagnosis. Fellows going through the motility component of their clinic month rotation are encouraged to attend this conference. Additionally, motility lab working rounds take place each Monday at 8:30 AM in B0007 in the GIP unit.

Fellows have the option of attending our Liver Program's hepatobiliary transplant conference held the 1st and 3rd Wednesday of each month from 12:30 p.m. to 1:30 p.m. in the Aventis Conference Room on the first floor of the Cancer Hospital. The liver fellow is expected to attend this conference.

Fellows have the option of attending the Transplant Selection Committee meeting every Wednesday from 2:00 p.m. to 3:00 p.m. in the Transplant Clinic area on the 4th floor of the Old Clinic Building. The liver fellow is expected to attend this conference, in addition to the liver histopathology conference given by the Department of Pathology on the 2nd and 4th Wednesday of each month from 1:00 p.m. to 2:00 p.m. in the Surgical Pathology suite on the third floor (30149) of the Women's Hospital (room 30208).

It is expected that fellows in the combined MPH/clinical epidemiology program attend the epidemiology research seminar from 4:00 p.m. to 5:00 p.m. each Wednesday in 4137 Bioinformatics Building. Clinical fellows who will do epidemiology work later on are encouraged to attend this highly informative conference. This seminar is an excellent venue for the exchange and dissemination of physician practice and career pearls, comparative effective research strategies, database programs, "brainstorming session" where attendees are encouraged to bring ideas, specific aims, works in progress, or papers to present and discuss with the group, and practice sessions for DDW. This year, Dr. Anne Peery is working with the schedule for this seminar, which Dr. Seth Crockett coordinated last year.

Dr. Balfour Sartor and members of his lab have a meeting each Monday from 9:15 – 10:30 AM in room 8201 of our Biomolecular Building. Dr. Scott Plevy and members of his lab have a meeting each Wednesday from 1:00 – 3:00 PM in room 7201 of our Biomolecular Building. Dr. Christian Jobin and members of his lab have a meeting alternate Thursdays from 9:15 – 10:15 AM in room 7201 of our Biomolecular Building (MBRB). This building houses our IBD labs and administrative offices on the seventh floor and is located on Mason Farm Road across from the ACC Building. Additionally, Dr. Susan Henning and her Stem Cell Research Lab meet the 2nd and 4th of each Monday from 8:30 – 10:00 AM in room 4201 of MBRB, as well as a general UNC Stem Cell

Research Group talk the 2nd Monday of each month (excluding June – August) from 4:00 – 5:00 PM in room 3200 Thurston Bowles (the back of this building contains a café and faces the front of MBRB.)* This conference presents works in progress from researchers within various disciplines at UNC and in the greater Triangle area towards the exploration of potential collaborations. Presentations are welcome from graduate students and post-docs, as well as faculty members.

*For 2012-2013, due to construction, the venue has been moved to the Genetic Medicine Building room 4007 (room 5007 for the months of Oct-Nov-Dec 2012).

EDUCATIONAL COMMITTEE

In 2004, an educational oversight committee was created as a way to evaluate our curriculum and need for clinical slots and to develop a mission for our fellowship program, with goals for the future. To date, Dr. Madanick heads the committee, whose members include Joanna Herath, administrator, Dr. Balfour Sartor, research training director, Dr. Lisa Gangarosa, former clinic director, Dr. Ian Grimm, endoscopy director, Drs. Kim Isaacs and Nick Shaheen, education coordinators/curriculum development, Dr. Tom Nuzum, outpatient education coordinator, Dr. Jama Darling, hepatology, Dr. Sid Barritt, junior faculty representative, Steve Kennedy, fellowship program coordinator, Dr. Brock Miller, senior fellow, and Dr. Laurie-Anne Swaby, junior fellow.

SUPPLEMENTAL EDUCATIONAL MATERIAL

FELLOWS' "MINI-LIBRARY": As of 2006, because of donations and, in large part, pharmaceutical sponsorship, we have been able to provide textbooks for GI fellows, paid from our fellowship educational fund. The fellowship coordinator keeps a master list of textbooks ordered; as long as the request is reasonable, a fellow can choose texts of interest and benefit to him or her. This list has expanded to include textbooks recommended by fellows, not previously on the list. Additionally, we have purchased textbooks to house in the fellows' space for general use during their clinical involvement.

A fellow cannot sign off on any letter of agreement to accept funds from a drug company. These forms must be processed according to set protocol because any educational grant given to our fellows for the purchase of library materials or other items are considered gifts rather than contracts and therefore must go through Helen Snow in the Office of Educational Development, phone 2-9589, fax 3-3314, CB# 6100. The fellowship program coordinator can and does, however, order textbooks requested of fellows for their personal use, dependent upon reasonable cost and availability of funds in our GI fellowship educational account.

Dr. Ian Grimm keeps Gastrointestinal Endoscopy journals that fellows are welcome to borrow, only he asks that they be returned in a timely manner. Additionally, he keeps 70 ASGE endoscopic video learning tapes that he is generous enough to loan to our fellows, of which he keeps track by a check-in/out system. Again, Dr. Grimm does not mind and wants to encourage fellow use of these tapes; however, in the past fellows who have checked out tapes have not returned them in a timely manner. You are always welcome to check out the same tape or borrow another one, but please return them when indicated.

Sleisenger and Fordtran's Gastrointestinal and Liver Diseases e-edition includes a CD-ROM with image library and online access. This is a good resource tool for downloading images/tables/figures for powerpoint presentation.

Physicians Practice Pearls is a free weekly newsletter from the publishers of Physicians Practice, the business journal for physicians. This newsletter provides an insider's perspective on the latest issues affecting medical practices. To review the current issue of the journal or to read archived articles, visit www.PhysiciansPractice.com. If you wish to receive this journal by email, email your request to pearls@physicianspractice.com.

The AMA now offers the Introduction to the Practice of Medicine (IPM) program, a Web-based educational series to help educate residents in ACGME general competency requirements and supplement their education in a variety of non-traditional curricular topics. Developed by the AMA through collaboration with the Ohio State Medical Association and the Ohio State University Medical Center, IPM features:

- Accessibility 24/7, so residents can complete the modules and post-assessments at their own convenience;
- Easy navigation, with quick access to learning modules, assessments, reports, and a host of other features;
- Comprehensive library of more than 20 learning modules, assembled by experts from across the country, covering such topics as health care quality, physician employment contracts, and sleep deprivation;
- Extensive reporting features, making it simple to track and document progress.

For more information about this program, please contact Marie Cruz at 312-464-4698, email ipm@ama-assn.org.

ADMINISTRATIVE DUTIES EXPECTED OF FELLOWS

- The fellowship director and coordinator must be notified of your absence. The fellowship coordinator receives various calls pertaining to fellows and needs to know this. Each fellow receives three weeks (15 days) of vacation per year and must clear this with the fellowship director. It is not intended to be used as the last three weeks for terminal leave. Ideally, the fellowship director would like to know vacation time in advance for incorporation into the yearly schedule. However, it would be good to notify Mary Alston of the GI Clinic within two months or earlier prior to blocking a clinic. Senior fellows must be careful with vacation time because they may need to use it in preparation for their departure. These fellows are allotted an extra week (5 days) to interview for a job. If a fellow is unreachable and is supposed to be on the premises, this time will be counted as vacation time. If a fellow takes vacation time beyond the amount allowed, s/he must take leave without pay or extend his or her fellowship. If a fellow switches rotations with another fellow, the fellowship coordinator needs to know this as well. If a fellow needs to be away during some part of a rotation, the precepting attending must approve this.
- In no way is a fellow permitted to cancel a continuity clinic or cancel or reschedule individual patient appointments. Mary Alston of the GI Clinic schedules fellows' appointments and manages their templates. If any changes need to be made, the fellow must request approval from Dr. Gangarosa, Clinic Director.
- Answer patient calls promptly. The fellow should check his or her voice mail twice daily, in the a.m. and in the p.m., and take care of patient calls as soon as possible.

- Complete and sign all requested and required forms in a timely manner. The fellowship coordinator has a tray in the fellows' space for this purpose.
- The fellow should check his or her clinic notes for electronic signature twice daily, in the a.m. and in the p.m.
- The fellow should check his mailbox once daily and make sure papers are removed so that our mail delivery person has no trouble delivering mail.
- Return email correspondence from the fellowship director and coordinator in a timely manner. If one requests something be done, please carry this out as time permits.
- Return all pager calls within a reasonable frame of time, as time permits. If the fellow is supposed to be on the premises, s/he should be nearby to return pager calls.
- Return any items borrowed or used to the respective person or back to its proper place.
- When dictating on Escript, please try to minimize wordiness or 'padding' of documentation. Additionally, remember to address key points of an exam so that we can obtain a higher level of coding for billing purposes. Do not code clinic or procedural services: this is to be done in consultation with the attending or by the attending him/herself. When dictating, always remember to state the precepting attending's name clearly at the beginning of all dictations. For daily progress notes, make sure each states a diagnosis. Please make sure that consult notes are legible.
- Please take into consideration the volume of work processed by our schedulers in GI Procedures. Do not schedule a procedure for a patient unless discussed with the attending first, whose secretary should also know of this. Do not add on patients for 'to do' procedures in slots not available or for rooms unassigned. Do not let requisitions accumulate for review.
- Please make sure that prescriptions are legible and that the proper medication, its form, and dosage are correct, observing the limit of maximum dosing. If it involves something like a prednisone taper, please be clear about the gradation of the taper.
- A fellow can have only one assigned pager, one internal email address, and one parking permit.
- Do not wait until consult sheets are below stock to notify the fellowship coordinator. It takes a while for these to be printed, and it is essential that we have a continuous supply of them. Similarly, if the indicator for 'toner low' appears on the fellows' fax machine or printer, please notify the fellowship coordinator at that time so that he can replace the toner cartridges and service will not be interrupted. Of note, fellows are to use the fax in their space or in the GI procedure conference room and not the one in the receptionist area. This has been an ongoing problem in the past—please be considerate of the GI procedure receptionists—they need uninterrupted use of their fax machine for requisitions.
- If a fellow changes addresses/phone numbers during his or her training with us, s/he must notify the fellowship program coordinator of this. This is quite important because of reporting of yearly income tax, payroll purposes (a fellows' last check is mailed to his or her

residence), and keeping an accurate update of fellows' information for GME tracking purposes.

- Please do not sign off on any documents provided by drug reps regarding educational materials, such as textbooks, for general fellows' use without consulting the fellowship program director.
- Make sure to lock the door to the fellows' space (B027 Main Hospital) after hours. There have been some thefts in the past.
- If you are already a resident at UNC, it is good to make sure that your former patient caseload has been assigned to another resident.

CODE OF CONDUCT EXPECTED OF FELLOWS

- It is not the responsibility of the fellowship coordinator "to look out for" any fellows during their training with us.
- If a fellow arranges to cover for another fellow who promises to return the favor, that fellow is expected to do so.
- 'Back up' does not mean to 'replace' a fellow, but to 'assist' this fellow.
- A fellow should respect his/her precepting attendings and value their constructive criticism. Our attendings are outstanding in their respective specialty areas, from whom a fellow—with an open mind and a positive attitude—can learn a great deal. The purpose of a 'training' program is to learn and grow, both professionally and personally.
- A fellow should respect his/her fellow coworkers and not take advantage of another coworker's kindness. Kindness should not be viewed as a 'weakness' that one feels s/he can take advantage of. One fellow should not expect another coworker to do his or her work. Everyone should be equitable and pull their fair share of the weight towards the common good of all. This means that each fellow should be a team player and that s/he must be responsible and accountable for his/her actions. This means that a fellow should be on time for scheduled appointments and procedures.
- A fellow should demonstrate good personal hygiene and present him/herself as well groomed in clean attire. We provide free laundry service for the washing of lab coats. The fellowship coordinator takes care of this. Scrubs are picked up and dropped off in GI Procedures.
- Please keep in mind that, as subspecialists, a fellow should not serve as a patient's primary care physician; this is particularly important with regard to narcotics.

DRESS CODE

When in clinic, men should wear a dress shirt and tie with their lab coat. Women should wear appropriate dress with their lab coat. Lab coats should be clean. When on consult service, dress can

vary. People should be aware of wearing comfortable shoes because of extensive walking. Men and women can wear similar dress, as in clinic. When doing travel cases, one should wear scrub top and trousers or full scrubs, all with their lab coats, and possibly shoe covers. When in the endoscopy unit, most individuals wear scrubs, either scrub top and trousers or full scrubs, with shoe covers. Usually a green gown is worn. (In the fall of 2006, our traditional blue gowns were replaced with green ones, as provided by the hospital. There has been the issue of blue having always provided a distinction between those in the procedures unit and those in the surgical unit, who wear green.) There are plastic aprons one can wear, and most workers are encouraged to wear eye shields (or their glasses). In the ERCP/fluoroscopy suite, individuals are required to wear lead aprons. In lab areas, individuals should not wear open-toed shoes due to possible chemical exposure. Individuals performing surgeries on mice and other animals should always wear gloves.

UNC Health Care workers who provide direct patient care should not wear artificial nails or extenders. The CDC has linked artificial nails to infections in patients. HC workers should demonstrate proper hand hygiene and, in the appropriate setting, wear personal protective equipment (PPE) as needed (hair cover, eye shields, surgical mask, gloves, gown, isolation gown, shoe covers) to keep from coming into direct contact with blood or body fluids.

Isolation gowns should be worn in the presence of patients placed on contact precautions. Hands should be washed thoroughly with antibacterial soap and water. Rubbing alcohol can be used as well, except in the cases of patients presenting with gastrointestinal viruses such as C.difficile, norovirus and rotavirus. No open-toed shoes are permitted in the immediate hospital setting.

CHECK-OUT PROCEDURE

GME requires that all residents and fellows leaving UNC complete a clearance form (see attached), which must be signed and dated by a representative of each area. Once this form is completed and signed, it is submitted to the GME Office, at which time the fellow is given his or her 'completion of training certificate'. The fellow's completion of training certificate and final paycheck will not be issued to the fellow until this form is completed. The following areas with their respective contact people and/or items must be taken care of as part of the check-out process:

- Cashier's Desk (Main Lobby of the Hospital) – Tammy Kenion, 6-4704
- Patient Accounts (Outpatient Registration) – Diane Payne, 6-1234
- Medical Information Management (Doctor's Workroom) – Linda Molter, 6-1046
- Health Sciences Library (Circulation Desk) – Karen High, 2-0800
- Parking, Emergency Parking, Hospital ID Badge, UNC Copy Card, UNC One Card, Access Card to Bioinformatics/Biomolecular buildings, Office Key, and Pager need to be returned to Steve Kennedy. (The office key may be returned to the nurse supervisor of GI Procedures, who actually orders and distributes keys for that area.)

If a fellow has an outstanding account with Health Sciences Library, his or her final paycheck will be withheld. (This should be taken care of and cleared when s/he checks out with the library as part of the procedure per above.)

Medical Student Education

Each year, our School of Medicine Chapter of the American Medical Women's Association (AMWA) hosts a residency fair, generally held the last Friday of March, from 12:30 pm to 2:00 pm in Berryhill Hall. Dr. Georgette Dent, Dean of Student Affairs, opens the fair, after which medical students have the opportunity to meet residents and obtain information about the various residency programs at UNC. The aim of this fair is to provide first- and second-year medical students with an introduction to residency opportunities and the residency application process. Last year, residents set up booths on the fourth floor of Berryhill. This set up allowed interested students to tour the different residencies represented at the fair and interact with residents in their programs of interest. Last year, the event was a huge success, with an impressive turnout of medical students at all levels and residents representing fifteen departments. Please feel free to contact Mara Vollkommer at mara_vollkommer@med.unc.edu with any questions.

Our division sponsors the second-year medical course in GI. If one goes to the School of Medicine web site <http://syllabus.med.unc.edu/yr2/gi/>, our current GI course schedule and contents are posted. This provides an excellent overview of all GI systems, both in course description text format and in powerpoint slide format. The Introduction to Clinical Medicine course for second-year medical students invite our faculty and fellows to participate in teaching seminars, in particular on how to do the abdominal exam portion of the PE in the clinical setting. Each year during the month of September volunteers from our division are asked to help teach this. If you are willing to participate in this activity when it is offered, please notify Dr. Shaheen, nshaheen@med.unc.edu.

The School of Medicine has a specific policy on the appropriate treatment of medical students. This policy defines maltreatment as sexual harassment in the form of discrimination based on race, color, religion, gender, national origin, sexual orientation, disability and age, in addition to purposeful humiliation, verbal abuse, threats or other forms of psychological mistreatment, and physical harassment/endangerment/harm. All members of the Department of Medicine should be aware of this policy and report violations properly, www.med.unc.edu/curriculum/.

On 9/26/06, the clinical curriculum committee adopted guidelines for work hours for medical students. Those guidelines can be found at <http://www.med.unc.edu/curriculum/Administration/policy/04%20policies%20Article05.4F.pdf>, on page three. The guidelines mirror resident work hour expectations, suggesting that students work clinically no more than 80 hours per week, stay no longer than 30 hours at one time, and have an average of four days off per month. The absence policy for students is outlined on page 4 of the same link above. Essentially it states that students can have no more than two (2) absences in a one-month rotation, and it provides guidelines for which absences are considered excused. This guideline was put into place to limit students interviewing for residency, testing, or traveling during important fourth-year rotations. In our current clinical curriculum, each student can have at least two months free from rotation to attend to those essential tasks. Additionally, four-year rotations end on the last Friday of the rotation block at 5:00 PM. The students are provided a weekend break between fourth-year rotations to allow them to travel to away rotation sites, if necessary, and to assure that they begin subsequent rotations the following Monday without difficulty. All fourth-year students should be appropriately released from clinical duties on the last Friday of their rotation at 5:00 PM and not asked to stay later or through the weekend after their rotation has ended.

Medical students, residents, and observers visiting and/or rotating through our program are asked to complete a teaching evaluation on attendings and fellows.

LOANS

GME fellows on hospital payroll may qualify for loan amounts based on PGY salary by filling out a request for authorization to have this deducted from your pay. The amount of deduction is prorated according to the amount of the loan and would be deducted from your pay within the current academic year.

Some fellows have had to defer payment of loans from varying institutions, including Sallie Mae Servicing Corporation, POB 9500, Wilkes-Barre, PA 18733-9500, 1-800-848-1949 (fax) and Wells Fargo Education Financial Services, 301 E 58th Street, North, POB 5185, Sioux Falls, SD 57117-5185. Deferment requests have also been made to the Federal Family Education Loan Program, Citibank USA, NA, POB 6192, Sioux Falls, SD 57117-6192. One can also check out the web site www.ManageYourLoans.com.

As of 9/1/03, NIH began accepting applications (due by November 30 at 5 pm EST) for five loan repayment programs. The National Institutes of Health Loan Repayment Programs (LRPs) can repay up to \$35,000 per year of qualified educational debt for health professionals pursuing careers in clinical, pediatric, contraception and infertility, or health disparities research, in addition to clinical research for individuals from disadvantaged backgrounds. Applicants must have a doctoral-level degree, devote 50% or more of their time to nonprofit- or government-funded research, and have educational debt equaling at least 20% of their institutional base salary. U.S. Citizens and permanent residents may apply. The program also provides coverage for federal and state tax liabilities.

The NIH Loan Repayment Programs are a vital component of our nation's efforts to attract health professionals to research careers in areas of national need. For information, visit the web site at www.lrp.nih.gov, contact the LRP Helpline at 866-849-4047, or email lrp@nih.gov.

Additionally, the National Health Service Corps (NHSC) helps ensure an adequate supply of health professionals to provide primary health services to people living in designated health professional shortage areas: 5600 Fishers Lane, Room 8A-55, Rockville, MD 20857, phone 301-594, 4400, toll free 1-800-638-0824. The Health Resources and Service Administration (HRSA), a division of the US Department of Health and Human Services, has a loan repayment program in regard to NHSC activity and involvement by visiting www.nhsc.bhpr.hrsa.gov/.

For VA loans to refinance or GI Bill educational benefits and other military benefits, you may visit www.military.com or email br@brm22.us. *Current fellows salaried through the Military must adhere to individual agency policy regarding bonuses, travel reimbursement, and receipt of in-kind gifts.*

Fellows interested in learning more about financial planning, insurance, disability, investments and loan consolidation are encouraged to contact Dan Hartley, financial services professional of the MassMutual Financial Group, with offices located in Charlotte, NC and Columbia, SC. Mr. Hartley's contact information includes 803-407-1882 (office); 803-730-5739 (mobile); 803-749-3219 (fax). The agency's web site is www.massmutual.com. MD Preferred Services, a service network for physicians, is created for graduating residents and fellows and meets a set of criteria to ensure excellent service tailored to the unique situation of each physician. This expanding network provides access to a) legal services, b) real estate services, c) relocation services, d) mortgage services, e) physician job services, and f) news service. These essential resources are selected and customized for physicians at no cost or registration: www.mdpreferredservices.com.

Physician Loans, www.physicianloans.com, has been in business since 1993 and offers various products in 17 states. This company continues to offer a 100% loan to physicians, as long as the property being purchased is located in one of those 17 states. For those completing residency or fellowship, one of the main benefits of this loan is that it allows the buyer to close on the home up

to 60 days before starting the new position. Please visit their web site or contact Tal Frank, Vice President, at 404-321-3931 or toll free 877-913-6286, ext. 5057.

BOARD REVIEW COURSES

We do not pay for board review courses; however, for interested fellows, William M. Steinberg's 'Board Review in Gastroenterology' held during the fourth week of September provides a comprehensive and in-depth overview of GI systems: esophagus, stomach and duodenum, small bowel, large bowel, liver and pancreas. William Steinberg, M.D., Clinical Professor of Medicine at George Washington University in Washington, DC, serves as the course director. This is the 15th annual Board Review in Gastroenterology course.

This review course is designed for fellows, physicians in practice preparing to take the certifying or recertifying board examination, and/or those who desire a comprehensive review of GI systems. At the conclusion of the course, participants should be able to

- Increase their knowledge base in preparation of their successful completion of the certification and/or recertification examination in Gastroenterology;
- Describe the diagnosis and management of disorders of the esophagus, stomach and duodenum, small bowel, colon, liver, pancreas and biliary tract.

Registration fees include \$995 for physicians and \$795 for fellows. For fellows, a letter verification of status is required. If you are interested in videotape and audiotape packages from the previous course, visit www.giboardreview.com or call 1-800-284-8435. If you would like to register for a course, please go to the aforementioned site. If you have questions or concerns, you may contact Travel Destinations Management Group, Inc. (TDMG) at 1-800-283-1997 or 410-363-1300 or via email at giboardreview@traveledst.com. The fellowship coordinator has assembled materials from past Steinberg GI board reviews (2005) and compiled them into 'GI Board Review Questions' volumes I and II.

To register for the NY GI Board Review, located at 85 Raritan Avenue, Suite 125, Highland Park, NJ 08904, visit on line at www.nygiboardreview.com or call 732-246-4296 (email info@nygiboardreview.com). This course offers a 1,200 page syllabus, 55 lectures, and 45 CME credits.

The Mayo School of Continuing Medical Education also offers a gastroenterology and hepatology board review course designed for candidates preparing for certifying and recertifying examinations in gastroenterology. The program includes relevant topics such as pathology, endoscopy, radiology and nutrition. Also included are interactive case presentations, lectures utilizing case-presentation format and multiple short board examination-type questions and answers. Included in the program is the *Mayo Clinic Gastroenterology and Hepatology Board Review* textbook, whose authors teach the course. Upon completion of the program, participants should be able to

- Identify esophageal, stomach, small bowel and colon diseases and other disorders of the gastrointestinal tract;
- Articulate diagnostic and therapeutic approaches to management of patients diagnosed with digestive diseases;
- Discuss integral relevant areas of pathology, endoscopy, radiology and nutrition;

- Simulate questions they are likely to encounter, both during the board examination and with patients;
- Improve examination skills to assist in successful writing of the certification/recertification examination in gastroenterology.

If you are interested in taking this course, please call 1-800-284-8433 (fax 1-800-284-5964) or visit the web site www.cmeinfo.com. This web site also contains information regarding home-study details. We have a Mayo board review course (2008), a 32 CD set kept in the fellows' workroom on the shelf in the far left corner of the room.

Additionally, for the fifth consecutive year, thanks to a generous, unrestricted educational grant from Wyeth Pharmaceuticals, all fellows can receive a complimentary 540-page review manual, updated every other year (updated in 2004) to aid them in preparation for their board exams. This text can also be used as an aid to help in fellowship studies. Castle Connolly Graduate Medical Publishing, Ltd., is the publisher, with M. Michael Wolfe, M.D., as Editor-in-Chief and Robert Lowe, M.D., as Associate Editor-in-Chief. This manual includes an overview of the following GI areas: biliary disease, colorectal disorders, esophagus, GI disease in the critically ill patient, GI malignancies, GI tract and systemic disease, inflammatory bowel disease, non-viral liver disease, nutrition, pancreatic disease, pharmacologic GI, small bowel disease, stomach, and viral hepatitis and represents literature by experts from Boston University School of Medicine, Harvard Medical School, Hospital of the University of Pennsylvania, Indiana University Medical Center, UCLA School of Medicine, University of Arizona, University of Michigan, University of Pittsburgh, and Washington University School of Medicine. Castle Connolly is located at 17 Battery Place, Suite 643, New York, NY 10004, phone 216-644-9696 ext. 1, fax 212-202-4972, general email info@ccgmp.com, specific email to Ms. Connie Johnson, cjohnson@ccgmp.com. Michael D. Wolf, Ph.D. serves as the Executive Vice President, MWolf@ccgmp.com.

As of 9/04, Dr. Sandler has approved using proceeds from the fellowship educational fund to purchase a Digestive Disease Self-Education Program (DDSEP), an interactive review for GI Boards developed by the AGA. The most updated version is DDSEP VI (2010). AGA member trainee price is \$325. We have ordered this program for our fellows' mini-library for general use. The web site for this program is <http://www.gastro.org/edu/ddsep.html>. A promotional version of DDSEP V appears on our fellows' resource site, www.unc.edu/~dfrantz.

DDSEP was initially developed in 1998 as the first multimedia, fully integrated self-education program for gastroenterologists and GI trainees. This fully integrated, highly interactive program brings medical education to life by combining the power of multimedia and the best in GI expertise. Virtually all digestive disease topics are addressed, providing the reviewer with the most comprehensive coverage of GI of any other program.

DDSEP VI features new content, new contributors and critical and informative updates in key areas of gastroenterology, including hepatitis, esophageal disease, and IBD. DDSEP VI contains over 300 new questions and critiques. Learning objectives include

- Assess and apply knowledge of digestive diseases pathology and pathophysiology;
- Describe the natural history and epidemiology of important digestive diseases;
- Choose the appropriate diagnostic and treatment interventions associated with digestive diseases;
- Identify unique aspects of certain digestive diseases in children;
- Apply the principles of nutritional assessment and therapy related to digestive diseases.

Hospital Physician, endorsed by the Association for Hospital Medical Education (AHME) provides an up-to-date resource designed as a review tool and reference guide for preparing for Board certification and recertification examinations. The Hospital Physician Board Review Manuals are developed and edited by clinical educators with experience in residency and subspecialty (fellowship) training who understand the needs of physicians preparing for Boards. Each volume contains 4-6 publications per year, each one focusing on one or more major topics within that specialty or subspecialty. The manuals foster the application of facts and concepts by presenting basic science and issues of diagnosis and treatment with current references to facilitate further learning. To receive complimentary copies of the Hospital Physician Gastroenterology Board Review Manual, visit the Web at www.turner-white.com. Once on the Web site, click on the 'Board Review Manual' tab at the top of the page, select 'Gastroenterology', click on "Request this issue" and complete the form. (This request is for the current issue; to receive back issues, please click on "Back Issues.")

This site also contains the peer-reviewed Hospital Physician, which includes practice strategies for residents and practicing physicians; the peer-reviewed Seminars in Medical Practice, which links ACGME competencies to clinical practice; and the peer-reviewed The Journal of Clinical Outcomes Management, which contains evidence-based, practical information for improving the quality of health care.

The fellowship coordinator has developed an on-line curriculum to help fellows prepare for GI boards using Powerpoint slides and PDF files of presentations at our weekly pathophysiology and clinical case conferences given by attendings and fellows. These appear as part of the orientation materials developed by the coordinator for all GI fellows, located on our division J drive.

In the spring of 2005, for the first time, the AGA has offered an inservice training exam, similar to the inservice training exams taken during residency. It is designed to let fellows know their strengths and weaknesses. Cumulative data from the exam helps the program director know which areas we are teaching well, and which we are not. The exams are not used to 'grade' the fellow in any way, and AGA specifically requests that the fellow not study for them. Cost of the exam is \$250 per taker, which the division pays for. Each spring the exam, proctored by the fellowship coordinator, is administered within a two-week time frame to allow flexibility in the fellows' schedule, lasts 3.5 hours, and comprises 170 multiple choice questions. All clinical fellows are required to take this exam and should be excused from normal service duties to take it. Research fellows make take this exam as an option. To learn more about this exam and its content, scoring, and score reports, visit the GTE (Gastroenterology Training Exam) site at <http://www.gastro.org/careerDev/GTE.html>.

In June 2004 the AGA developed a new gastroenterology teaching project (GTP): 'The Genetic and Molecular Basis of GI and Liver Disease', containing nearly 300 high-quality images, which review advances in molecular biology and genetics and apply these concepts to understanding the epidemiology, pathogenesis, molecular mechanisms, and treatment of gastrointestinal and liver diseases that have a defined genetic basis. Sections include 1) molecular biology basics, 2) genetic diseases, 3) molecular biology – cell proliferation, 4) molecular biology – tools. The program includes animations and illustrative case studies. Other available programs are IBD – Pathology, IBS, Pancreatitis (also in Spanish), and Viral Hepatitis. Soon the AGA will come out with 'Gastrointestinal and Liver ClipArt', a unit that will allow one to create or modify slides using artwork created over the past years for GTP units. The AGA's GTPs provide high-quality images for use in teaching complex concepts and processes or for use in developing presentations of any format or duration. The fully searchable units are available on CD-ROM in their entirety or can be downloaded in their entirety or in defined sections. To preview available images and legends, obtain pricing information, and order, visit www.gastroslides.org.

The Waterford Group provides free board examination study tips for all residents and fellows by going to their website at www.twgj-1waiverjobs.com and clicking on the 'Guest Book' link on the homepage. This takes you to a page where you can sign in and access a free report entitled "Board Examination Study Tips." For more information, contact Paul Harris of the Waterford Group, 10 Town Plaza # 124, Durango, CO 81301; phone 970-247-3945, fax 970-247-3946, email waterford@frontier.net or dic@frontier.net.

For a wide selection of board review books at reasonable prices, check out www.board-reviews.com.

PROGRAMS FOR YOUNG PHYSICIANS

A free online publication listing mentoring programs for physicians and physicians-in-training is available from the American Medical Association (AMA) Young Physician Section by visiting <http://www.ama-assn.org/ama/priv/category/6745.html>. "Mentoring Programs for Medical Professionals" identifies programs for

- pre-med students
- medical students
- residents/fellows
- young physicians
- faculty

The Young Physician Section (YPS) of the North Carolina Medical Society (NCMS) is examining the issue of credentialing for new physicians. Several YPS members have reported long delays associated with credentialing for several health insurance plans. This issue is also being examined by the AMA-YPS on a national level. Despite graduating from accredited residency/fellowship programs and achieving board certification, many young physicians out of residency or fellowships are experiencing delays ranging from two to six months. Not only does this make it nearly impossible to establish a solo practice, it makes payments to the new-practice physician non-existent for the first two to six months of practice, depending on the insurer.

The YPS in conjunction with the NCMS Foundation and Wachovia Bank have partnered to provide educational programs on financial planning and debt management for physicians and their families. The program can be tailored to meet the needs of members, from debt management for residents and new physicians, to planned giving and estate planning for physicians further into their medical careers.

For more information about YPS, contact Shawn Scott, NCMS Director of Member Services (sscott@ncmedsoc.org), or Pam Highsmith, Associate Executive Director, NCMS Foundation (phighsmith@ncmedsoc.org), at NCMS Headquarters, 919-833-3836.

<http://www.med2020.com> is a free site used widely by private practices, hospitals, community health systems, and universities to list directly their physician employment opportunities. Med2020 is a multi-specialty web site that gives all physicians a convenient, user friendly, effective way to find the best available jobs. By using Med2020 physicians can choose to be notified automatically by email when jobs are posted in their specialty and preferred locations.

Med2020 has other professional and personal resources for physicians; it contains a comprehensive and current online CME Directory listing every type of CME, professional resources including links

for career development, medical and professional association links, medical state licensing boards, disease guidelines, health regulatory sites, and medical literature. The book The Successful Physician Negotiator – How to Get What You Deserve is also available on Med2020.com and discusses what a physician should know before negotiating and signing any employment or partnership contract. The magazine *Medical Economics* highlights latest research and its economic implications and other important issues, such as money and practice management, malpractice, civil rights, and IRS rules and regulations. This can be viewed at www.memag.com.

Fellows can also check out career opportunities by visiting www.nejmjobs.org and www.physicianrecruiting.com (1-800-880-2028). Additionally, perhaps the best source for GI job placement is through www.gicareersearch.com, endorsed by the AGA. This agency provides assistance to candidates as well as to employers. To find out more, visit their web site or call 1-888-884-8242/email info@healthcareers.com. Other agencies include Residents Career Center (contact Ellyn Woodburn at giprograms@residentscarercenter.com) and www.medicalMatch.org.

Lorna Lindsey of CompHealth, Inc., provides career development presentations, upon request. Topics include

- Negotiating an Employment Contract
- The Art of Selling Yourself (writing cvs and interviewing skills)
- Malpractice Insurance and Risk Management
- Locum Tenens
- Exploring Your Career Options (includes information and tips on conducting a detailed needs assessment prior to the job search, tools for locating practice opportunities, and how best to use them, malpractice basics, state licensing, DEAs and NPIs).

Each presentation takes approximately one hour and can be scheduled to fit into a practice management series such as journal club meetings, a noon conference, or retreat. The content is flexible and can be tailored to meet the specific needs and interests of each resident. To meet ACGME requirements, the content of each presentation is strictly academic.

Ms. Lindsey has conducted hundreds of similar presentations at residency and fellowship programs across the country over the last 17 years. She has spoken frequently at national AMA meetings, specialty conferences, and state society meetings. The presentations are sponsored as an educational service by the Academic Affairs Division of CompHealth, a professional service healthcare staffing and credentialing firm. There is no charge for the presentation, designed solely to provide residents with valuable information. Lorna Lindsey is the Director of Academic Affairs at CompHealth and can be reached by calling 1-800-722-5766, fax 205-655-1756, email lindsey@comphealth.com, <http://www.comphealth.com>.

Physician Services is an agency that helps junior physicians prepare hospital privilege forms, insurance privilege forms, and state controlled substance/DEA forms. Physician Services is located at 9340 Helena Road, Suite F – 189, Birmingham, AL 35244, phone 205-746-4426, fax 205-663-9212, email physicianserv@bellsouth.net. Pat McGraw is president.

Mr. Chris Mitta is a financial advisor who helps set up disability and life insurance for residents as they transition out into the ‘real’ world. He has spoken to our fellows in the past and was well received. To contact him, his office number is 919-872-8666 (fax number 919-844-8250). He is located in Raleigh. In 2011 he began to offer individual supplemental disability insurance for salaried housestaff at UNC Hospitals. These contracts are individually owned and have a special

UNC rate for the life of the contract. These individual policies do not change the group coverage provided through Guardian Insurance Company. Individual policy highlights include

1. Noncancellable & Guaranteed Renewable: Once in place, you cannot be canceled or have your rates increased.
2. Own-Occupation Definition: States that you could still collect a benefit on a claim from your current specialty, even if you are gainfully employed at another job.
3. Residual Benefit: Allows you to collect a portion of your benefit when you are not totally disabled, yet you have loss of income.
4. Purchase Options: Allows you to buy more coverage in the future, regardless of your health. No health qualification is needed for this increase.
5. Portability: Upon completion of your residency, all plans are 100% portable, with no rate or definition change.

Please visit www.disabilityforresidents.com for more information.

At the GME residency web site, <http://gme.unchealthcare.org>, under 'current residents' where it designates 'benefits for residents' appears a financial planner provided by The Potter Financial Group. Also at the same site under 'residency links' includes Bank of America & Mortgage, Wachovia Banking & Mortgage, RBC Centura Banking & Mortgage, Regions Mortgage, and Integrated Mortgage Strategies, Ltd.

The fellowship program coordinator maintains a 30-page updated listing of job recruiting agencies throughout the US for BE/BC gastroenterologists. He also keeps a list of contact information for all former UNC GI fellows since inception of the program in 1952.

On January 26, 2011, Michael F. Merrill of the North Star Resource Group, 5100 SW Macadam Ave, Suite 200, Portland, OR 97239 (503) 423-2707 (toll free 877-641-2360 ext 360), fax 503-321-7402 hosted a 'Financial Planning for the New Physician' webinar at 8 pm EST. His associates addressed the main priorities residents and fellows should focus on in transitioning into practice, including employment contracts, debt management and budgeting strategies, ownership of occupation disability insurance, Roth IRAs and other retirement plans, and home buying. Spouses are welcome to participate in these webinars as well. A "webinar" is an internet/computer-based seminar in which participants receive a link to the actual webinar that allows them to join the meeting at the appropriate start time. They need computer speakers to hear the audio. Feel free to visit www.northstarfinancial.com. If you are interesting in attending a webinar, please call the toll free number above or email Mike at michael.merrill@northstarfinancial.com. North Star Consultants has been voted "2010 Best Financial Advisors for Doctors" by *Medical Economics Magazine*.

In 2010-2011, Jeff Turton, financial representative of North Star, held a series of financial strategies dinners for both UNC and Duke residents and fellows, held at Carolina Brewery in Chapel Hill and Parizade in Durham. These dinners have grown in popularity via word of mouth, as each dinner has had 50+ attendees, with ones being put on a waiting list. In 2010, four different dinners were arranged for this area, with another one offered in February 2011. Jeff is located at 201 3rd St., NW, Suite 1900, Albuquerque, NM 87102. If you are interested in attending an off-site dinner, please email Jeff at jeff.turton@northstartfinancial.com or phone him: direct (505) 247-1800 x 217; cell (505) 417-0384; toll free (800) 923-8781 x 217; fax (505) 247-1802.

There is a free email newsletter that includes information on practice opportunities in GI. Each posting includes a brief description of the opportunity as well as necessary contact information for

all inquiries. The web site is www.CareerMD.com. To sign up, send an email to Nathan Strom at nstrom@careermd.com or call him at 1-800-355.2626. In June of each year, CareerMD holds a Career Fair for residents and fellows at the Sheraton Chapel Hill Hotel from 5:00 – 9:00 p.m., with refreshments. Employers from all parts of the country attended, with much positive feedback from residents and fellows. The fair was open to residents and fellows at any stage of training and ideal for those wishing to pursue job options early. For information, contact Caitlin Rinderer at 1-800-355-2626, email Crinderer@careerMD.com.

Justin D. Nability of Physician Advisors, LLC, and his advisory group routinely speak on business and career-related topics to support residency and fellowship programs with their practice management curriculum. The most common topics requested are the following:

- How to Prepare for Employment Interviews
- How to Evaluate Compensation Packages
- How to Avoid Employment Contract Pitfalls
- How to Successfully Negotiate Employment Offers

Physicians from over 200 institutions and more than 500 training programs – including all specialties – have participated in their practice management sessions and benefitted from their resources. Justin may be reached at 877-744-9474 x 107; email Justin.Nability@PhysicianAdvisorsLLC.com, www.PhysicianAdvisorsLLC.com.

DocCafe.com presents a summer resident virtual career fair series. If interested, visit www.doccafe.com, phone 574-268-1100 or 574-453-3700, fax 574-268-9929, email doccafe@doccafe.com. ‘Pinnacle Resident eNews’ is an email newsletter for residents preparing for practice and includes such information as understanding physician employment contracts in addition to recruiting opportunities and useful resources. If you are interested in subscribing to this newsletter, please email Pinnacle News at resprograms@phg.com. The American College of Physicians (ACP) also has career information on their web site located at www.acpoline.org/careers as well as WebMD, www.webmd.com. The Journal of the American Medical Association (JAMA) has a site as well, which deals with career development and personal finance, www.jamacareernet.com. One can open a free account with www.MDspots.com for posting of your resume so that potential employers may find you. You may also contact Alison M. Inga, account executive, by email at ainga@mdspots.com or Info@MDspots.com. The Alliance of Medical Recruiters, founded in 1994, is a nation-wide network association of physician recruiters with a shared database of active physician practice openings. When a physician completes the on-line form, individual preferences are matched against their national database. The web site address to fill out the form is www.ExploreAMR.com. This service costs physicians nothing. The contact person is Marla Little, The Alliance of Medical Recruiters, 1352 E. Elm Street, Springfield, MO 65802, 800-886-0011. Visit www.docjobsonline.com, the web site for Coast to Coast Placements, Inc., Physician Recruitment Center, phone 321-452-4800, email info@docjobsonline.com.

Those newly established in practice may want to contact CRH Medical, which will provide at no cost

- didactic presentations and follow-up training and didactic sessions, as requested
- physician-to-physician instruction in the use of medical products
- 24/7 professional support
- coding/billing/contracting and operational support for both private and academic practices

You may review their website at <http://www.crhmedicalproducts.com>, which contains a plethora of information, including pertinent literature. The password for protected portions of the site is “learnmore.” Please feel free to contact the Mitch Guttenplan, M.D., medical director for CRH, at 770-363-0125 or by email at mguttenplan@crhmedicalproducts.com.

In December, the Physician Opportunities Convention takes place. This event features over 150 job opportunities for gastroenterologists in Georgia, North Carolina and South Carolina. If you have questions, please contact Melissa Mazzell at 843-216-5278 or email her at Melissa.Mazzell@hcahealthcare.com. You may visit the HCA Healthcare Southeast Division at www.practiceinsoutheast.com.

Each year the North Carolina Physician Practice Expo takes place in the lobby of NC Women’s Hospital during the first Tuesday of October. This is an expo for those who are interested in joining a practice in North Carolina. Representatives from hospitals and group practices are invited from across the state to provide information about the practice options available in NC. This event is sponsored by the UNC Health Care System and Carolina Physician Recruitment. For information, please contact Nancy Parker, network development specialist, at 6-4448 (fax 6-3815); email: nparker@unch.unc.edu.

The North Carolina Physicians Health Program is available to aid any physician whose health and/or effectiveness has been significantly impaired by chemical dependency, psychiatric illness, or behavioral issues. To seek assistance, call 1-800-783-6792. In 1988, the NC Medical Society and the NC Medical Board established a program to help impaired physicians, whose goal was identify those physicians headed for trouble due to chemical dependency or abuse, psychiatric/behavioral issues and to get appropriate treatment for them, monitor their aftercare, and return them to the productive practice of medicine. It was believed that most impaired physicians would have been in practice 15 to 20 years, eventually experiencing burnout. However, a major surprise has been that 17% of chemical dependency cases are housestaff trainees.

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