



# **Department of Pediatrics**

## **POLICY AND PROCEDURE MANUAL**

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## POLICY ON ~ AWAY ROTATIONS

1. The resident must have completed 24 months of pediatric training.
2. The resident must be in full compliance with the following mandatory resident activities prior to receiving approval to do an away rotation:
  - a. Resident must attend a **minimum** attendance of three continuity clinics per month and all clinics must be logged into the ACGME website.
  - b. Resident must see the required average number of patients in continuity clinic per level of training. As a PGY-1, resident must have logged an average of 3 patients/clinic and as a PGY-2, resident must have logged an average of 4 patients/clinic. PGY-3 residents must log an average of 5 patients/continuity clinic to be in compliance.
  - c. Resident must not be delinquent in conference attendance.
  - d. Resident must complete the required twenty PREP questions per month online.
  - e. Resident must complete all required online core curriculum modules.
  - f. Resident must complete all online faculty and peer evaluations via Residency Partner.
  - g. Resident must complete all outstanding charts in medical records.
3. The resident must be deemed competent in all core competencies and in a supervisory role. This will be ascertained based on the resident's faculty and peer evaluations.
4. The resident must secure medical licenses and malpractice insurance and present proof of confirmation of the above at a minimum of two weeks prior to departure.
5. The resident must demonstrate the necessity of the away rotation to provide a specific clinical or research education experience not otherwise available at the home institution.
6. The resident should develop a list of written objectives prior to departure.
7. The resident should identify a preceptor in the host country or at the host institution.
8. The resident should orient themselves with the host institution's policies and procedures prior to departure. If an international rotation, the resident should

- become familiar with the host country's climate, culture, politics, and health and safety issues.
9. If the resident is not fluent in the host country's language, arrangements must be made for translators.
  10. The resident should secure travel documents before departure.
  11. The resident should arrange housing and medical care for him/herself.
  12. The resident must be formally evaluated by their appointed preceptor at the completion of the rotation, primarily to identify satisfaction of his/her objectives.
  13. Upon returning, the resident should submit a written summary of his experiences to the program director and formally evaluate the elective with the appropriate faculty.
  14. The resident must participate in the call rotation at Children's Hospital, the sponsor institution of LSU Pediatrics to ensure payment of monthly salary. This can be scheduled at the beginning or end of the month the resident is away.
  15. The resident must receive prior approval from the program director and program coordinator prior to making any travel arrangements.



**Department of Pediatrics POLICY ON ~ CHIEF RESIDENT DUTIES**

The chief resident position involves administrative, teaching, and clinical responsibilities.

From an administrative standpoint, the chief residents are responsible for developing a yearly schedule for all interns and residents. This schedule needs to reflect the requirements put forth by the ACGME and RRC for pediatric house officers while at the same time providing appropriate coverage for inpatient and outpatient services. House officers from other programs (family practice, etc.) will also need assignment within this schedule. Chief residents will also be required to develop the monthly PER schedules. This should be completed 2-3 weeks prior to the start of the month and distributed to the appropriate residents and ER faculty in a timely manner. It is beyond the scope of the chief resident's job to provide daily scheduling for outpatient/elective rotations – the individual department heads should do this. In the event that scheduling conflicts should arise due to illness, pregnancy/maternity leave, death of a family member, etc., the chief resident should assist that person in his/her attempts to arrange alternate coverage (especially if it means utilizing the jeopardy system). The chief resident is also responsible for formulating special resident schedules in the event of a natural or external disaster (i.e., Code Grey) and will be required to be present at the hospital which they are covering during any such disaster.

Chief residents are also liaisons between the faculty and the house officers. In light of this, they will need to attend numerous meetings (RRC, Competency Committee, LSU Faculty Meeting, etc.) and relay this information to the housestaff. While their primary goal should be advocating on the residents' behalf, there may be times when disciplinary action is necessary, and the chief resident is responsible for initial interventions. The program director should be notified of any significant or ongoing problems.

Chief residents are an integral part of the resident recruitment process. All current and incoming chief residents will be part of the Recruitment Committee and will be assigned applications for review. The committee meets weekly during the heart of interview season to discuss the candidates and formulate the rank list. The chief residents are responsible for presenting the “Nuts and Bolts” of the program with interviewees. The chief residents should also assist in any efforts to provide interviewees with the opportunity to get to know current residents (i.e., lunches or recruitment parties) outside of the hospital setting.

One of the primary roles of the chief resident is that of teacher. He/She will conduct morning report (4 times weekly at Children's Hospital) in a manner that is geared toward intern/resident learning. The chief residents are also responsible for scheduling of all house staff teaching conferences (Noon Conference, M+M, and Case Conference) in accordance with ACGME/RRC requirements. In addition, the chief residents may round with the inpatient teams covering private general pediatric patients in order to provide

teaching to students and house officers. During these months, it is the chief's responsibility to provide evaluations for students, interns, and residents on those teams.

The clinical responsibilities of the chief resident are minimal. Occasionally, he/she may be asked to help with coverage in the Continuity Clinic. The chief residents will be allowed to take call for CHPA, if desired. All clinical work done on a faculty level will need to be co-signed by appropriate staff. Though the jeopardy system should limit the need for chief resident coverage of house staff absences, scheduling conflicts may arise that require the chief resident to cover a shift or service.



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CHILDREN'S  
HOSPITAL

## **POLICY ON ~ CODE GREY FOR LSU RESIDENTS & CHILDREN'S HOSPITAL**

### **CHIEF RESIDENT RESPONSIBILITIES**

- The Chief Residents are responsible for staying aware of the Code Grey situation at all times from the beginning (Code Grey Watch) until the code is actually completed. They will pass information on to the residents.
- The Chief Residents will be notified by the hospital administration at the time that the Code Grey is called.
- The Chief Residents are responsible for assuring that an adequate number of residents are on duty during the Code. One Chief Resident will be stationed at Children's Hospital during the Code Grey and will coordinate the call teams and arrange appropriate shelter for residents, with the assistance of hospital administration. That same Chief Resident will also be available for back-up coverage if it is needed on any of the teams. The remaining Chief Resident will evacuate with other evacuating residents and assist with organization of the recovery team and communications during the code.
- If a Chief Resident is unavailable for any reason, a designee will serve as the Chief Resident. This designee will be appointed by the Chief Resident or Residency Director.
- During the Code Grey, an LSU Attending Staff Member will be in the hospital to serve as an advisor to the Chief Resident.

### **RESIDENT RESPONSIBILITIES**

- All pediatric residents are responsible for knowing the Code Grey status. This will be communicated to them by the Chief Residents and via the Children's Hospital website ([www.chnola.org](http://www.chnola.org)).
- One upper-level resident from each of the ward teams will be available to care for patients during the Code Grey. Two upper-level residents will be present for both the NICU and PICU teams during the code. The Chief Residents may call in additional residents as needed. Upon notification of a Code Grey, upper-level residents on call that day and the next day should report to the hospital as soon as it is safe to do so. Once the Code Grey has been activated, no resident is allowed to leave the hospital unless approved by the Chief Resident.
- Pediatric residents will be expected to cover the pediatric medical patients on the floors and in the intensive care units with the help of attending staff. Call will be on an every-other night basis. In the event of an emergency involving a surgical patient, the pediatric residents will be available to see to the patient until a surgeon is available, as is

the case in non-disaster situations. Daily progress notes on surgical patients will be written by the surgery teams.

- If there are special circumstances that would prohibit an on-call resident from taking Code Grey call, said resident must notify the chief resident AND find a replacement. It is solely the activated resident's responsibility to find his or her replacement if circumstances prohibit him from working on the Code Grey team.
- Interns will not be called to work during a Code Grey.
- Interns and upper-level residents not called to work in the hospital during the Code Grey should leave the city if a mandatory evacuation is called. During the Code they should check the hospital web site ([www.chnola.org](http://www.chnola.org)) and their e-mail regularly for updates. Residents who evacuate should return to the city as soon as possible after the Code in order to relieve those who stayed.
- Every House Officer not participating in the Code should notify the Chief Resident either by phone or e-mail as to their expected location during the Code. This will assist the Chief Resident in composing the Recovery Team.
- Every Resident must provide an emergency contact name/number and a non-LSU e-mail address at the beginning of the year and keep the chief residents updated to any changes in this information.

#### **FAMILY MEMBERS**

- No family members are allowed due to inadequate space. No pets are allowed either.

#### **FOOD AND SHELTER**

- The hospital will provide food for residents within its ability. There may be a nominal charge for food served during the Code.
- Residents should bring extra water and food just to be safe though.
- Residents should also bring extra bedding, towels and necessary clothes and toiletries. The call rooms and designated patient rooms will be available for the residents to use for sleeping.
- During the event of a vertical evacuation, some resident space (e.g. the resident lounge) may be needed for other hospital functions.

#### **RECOVERY TEAM**

- During a Code Grey a recovery team will be created by the Chief Resident to relieve those residents who have stayed in the hospital more than 48 hours.
- If the Code Grey has lasted 48 hours or longer, those serving on the Code Grey team will be relieved of all duties for a period of 48 hours. The recovery team will be responsible for all patient care during that time. After 48 hours, all residents will be expected to return to their regularly assigned duties.



**Department of Pediatrics POLICY ON ~ CONTINUITY CLINIC**

1. Residents must attend one half- day session per week of continuity clinic for a minimum of 36 clinics per year throughout the three years of their residency training.
2. This experience must receive priority over other responsibilities and may be interrupted only for vacations and outside rotations located at too great a distance to allow for the resident to return.
3. Residents cannot attend continuity clinic when they are post-call. Residents are not required to attend continuity clinic while on night-float if a shift falls either the day of or prior to a continuity clinic day. However, residents must need to make up any clinics missed in order to obtain 36 clinics per academic year. Each month, the chief residents make a list of all excused absences from continuity clinics. The list is distributed to both the residents and clinic faculty. If a resident is in need of making up a clinic, it is their responsibility to find a day where there will be an absence and arrange approval from that clinic preceptor to attend that particular clinic for make-up.
4. Residents rotating in the PICU, NICU or a busy inpatient ward are not exempt from attending clinic.
5. Residents are expected to be on time to clinic as patients are waiting for them.
6. If a resident anticipates being late for clinic, they must contact an attending physician in their continuity clinic.
7. Residents must see a progressive number of continuity patients per clinic session, with a minimum of 3 patients in PGY-1, 4 patients in PGY-2, and 5 in PGY-3.
8. A log of patient information must be maintained as per RRC guidelines on the ACGME web site, [www.acgme.org](http://www.acgme.org).
9. Notification to clinic of vacation dates, post call days and post night float days is the responsibility of the resident, so that patients will not be scheduled for that resident.
10. Residents are responsible for notifying the clinic for changes or additional leaves of absence.
11. At the monthly compliance meetings the residents' documented clinic logs are reviewed. Residents who are non-compliant will be contacted by the chief residents. If there is a recurring monthly deficiency, the resident must appear

before the committee to explain these deficiencies and present a plan of action to meet the requirements.



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## **RESIDENT ELIGIBILITY FOR SELECTION**

First year House Officers must participate in the National Residency Matching Program (NRMP).

House Officers must be:

1. Graduates of Medical Schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduates of Colleges of Osteopathic Medicine in the United States accredited by the American Osteopathic Association (AOA).
3. Graduates of medical schools outside the United States who have received a currently valid certificate from the Education Commission for Foreign Medical Graduates or have a full and unrestricted license to practice medicine in a United States licensing jurisdiction.

All House Officer trainees must have a valid license or permit to practice medicine in the State of Louisiana. The Louisiana State Board of Medical Examiners will confer unlimited licensure only after the candidate successfully completes the post-graduate year 1 level and passes the USMLE Steps 1 through 3 or COMLEX Steps 1 through 3.

House officers candidates are selected by the Department of Pediatrics Recruitment Committee made up of the Program Director, Associate Program Directors, Chief Residents, Future Chief Residents, Medical Student Clerkship Director, and Program Coordinator. The selection is based on application, curriculum vitae, personal statement, grades, board scores and letters of recommendation. All applications are screened by the committee members and those who are felt to represent possible candidates are invited for interview.

House Officers are appointed for one year. Contract renewal is subject to mutual written consent of the Department Head and the House Officer.



## POLICY ON ~ EVALUATION

### Resident Evaluation

Recent trends in medical education and residency training have led to the development of a competency based evaluation method for assessing adequacy of training and acquisition of the necessary skills to practice medicine. The ACGME requires documentation of competence in six areas related to the practice of medicine. The six mandated competencies are:

- 1) Patient Care
- 2) Medical Knowledge
- 3) Interpersonal and Communication Skills
- 4) Professionalism
- 5) Practice-Based Learning and Improvement
- 6) Systems-Based Practice

While the first four are relatively self explanatory, the last two are less intuitive and are reviewed below.

Practice-based learning and improvement involves a continuous process of evaluating one's clinical practice in light of cumulative clinical experience and the rapidly expanding fund of available scientific knowledge. Residents must demonstrate the ability to make improvements in their practice based on this ongoing evaluation. All physicians must take responsibility for becoming life-long learners and be able to recognize one's strengths, weaknesses and limitations within the context of their practice.

Systems-based practice involves maintaining an awareness of and responsiveness to the entire healthcare system as it relates to the practice of medicine. This includes: knowledge of resources available within the healthcare system to optimize care, delivering cost-effective health care, risk management and the importance of reviewing medical errors to prevent further system errors, and the organization and financing of a clinical practice.

Documentation of competency during the course of your residency will be accomplished primarily through global evaluations submitted by supervising faculty members for each clinical rotation. This evaluation form addresses each of the competencies individually with additional comments provided at the end of the form. Other sources of feedback/evaluation include: 1) a 360 degree review which includes peer, nurse, patient and student input, 2) yearly In-service exam, 3) monthly PREP questions, and 4) completion of a quality assessment and improvement project during the third year of residency. Interns and residents will also take part in reflective practice exercises bi-annually as part of the professionalism/practice-based learning curriculum. As these exercises are often personal, they will not be formally evaluated by faculty members.

Instead, they will become part of each resident's portfolio for review during their third year exit interview.

1. All residents will be evaluated monthly by the faculty who is responsible for the rotation.
2. Residents will be evaluated by patients in their continuity clinic and on the inpatient teams.
3. Nurses in select areas of the hospital will evaluate the residents.
4. Medical students who rotate in pediatrics will evaluate the residents who supervise them.
5. Biannual review
  - a. Performed twice a year
  - b. Conducted by program director, associated program directors, advisors
  - c. Individualized Learning Plans will be completed using AAP Pedialink Residency Center, [www.pedialink.org](http://www.pedialink.org), which includes:
    - i. Future goals; strategies to assist in achieving these goals
    - ii. Self assessments
    - iii. Self – ratings of competency level
    - iv. Creation of learning objectives and strategies to accomplish these
  - d. Review of all evaluations
  - e. Review of in-training examination
  - f. Creation of a Portfolio documenting all formal teaching and learning activities and procedures
  - g. Review of ACGME procedure and clinic case logs

New Innovations: all evaluations of residents by faculty are entered on an internet site, [www.new-innov.com](http://www.new-innov.com). Residents can view their evaluations at all times by logging into this system using your assigned username and password. Residents will also be asked to complete faculty evaluations via this internet system.



**Department of Pediatrics POLICY ON ~ GRIEVANCE PROCEDURES**

1. The Department of Pediatrics Residency Program follows the guidelines set by the LSUHSC Graduate Medical Education, which are documented in the House Officer Manual at the below address: [http://www.medschool.lsuhscc.edu/medical\\_education/graduate/HouseOfficerManual](http://www.medschool.lsuhscc.edu/medical_education/graduate/HouseOfficerManual)
2. In addition, the Department has a Competency Committee which oversees the promotion and graduation of our residents. Meetings are held at least biannually and more often, if deemed necessary. The committee reviews all of the residents' progress as documented in their monthly evaluations. If a resident's performance is deemed substandard, the committee has the duty of creating a written remediation plan, discussing this plan with the resident, and following the resident's progress.
3. If an adverse action such as probation or dismissal is taken, the Chair and the Associate Dean of Graduate Medical Education will be notified.
4. The resident will be notified of his/her due process and has the right to appeal this decision. The resident must follow the timeline set forth by the Office of Graduate Medical Education.
5. Residents will be referred to the Campus Employee Assistance Program if personal problems, substance abuse, or mental illness are suspected by the committee.



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## **POLICY ON ~ HOUSE OFFICER MOONLIGHTING**

1. Moonlighting is defined as employment as a physician outside of the scope of the House Officer Program.
2. House officers must have written approval by the Program Director and/or Department Head before engaging in this activity. The Residency Office will maintain a moonlighting file of all the written approvals.
3. The Department of Pediatrics can withdraw permission for moonlighting if the resident's performance is substandard or any evidence of fatigue.
4. House Offices, while engaged in professional activities outside the scope of the program, are not provided professional liability coverage unless the services are performed at a public charity health care facility. For professional activities at Children's Hospital, residents must have additional malpractice coverage that is available through Children's Hospital Finance Department.
5. Residents must abide by the guidelines for moonlighting times.
  - a. Residents cannot moonlight the day before or the day after a regularly scheduled call day.
  - b. Residents cannot moonlight during an every 4<sup>th</sup> night call rotation month.
  - c. Moonlighting activities cannot interfere with required rotation duties which places restrictions on the timing of moonlighting activities. Moonlighting hours cannot conflict with the Resident Duty Hour Policy (see policy) and are counted towards the 80-hour work-week limits. Residents must have 4 days off averaged over a 4 week period; must have 8 hours off between duties and cannot work more than 24 hours consecutively.
  - d. Residents are limited to 5 weekday moonlighting calls/month
6. All moonlighting must be tracked in New Innovations' Duty hours.
7. Moonlighting by interns and J-1 visa holders is not allowed.
8. All house officers must be fully licensed by the LA State Board to moonlight e.g. have an unrestricted license, which usually means passing Step III and more restrictions for ECFMG holders.



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## POLICY ON ~ LEAVE

### **LEAVE**

The residency office or the chief residents must be notified for all absences. House Officers are granted leave benefits as described in the LSUHSC House Officer Manual. There is no additional leave granted for personal time.

#### **Job or Fellowship Interviews**

There is no allocated time for job interviews. Vacation leave is utilized for this activity. Absences for interviews can only be taken during outpatient rotations. The residency office and chief residents must be notified of these absences. It is the responsibility of the resident to arrange coverage.

#### **Vacation leave**

Post-graduate year 1 trainees are entitled to twenty-one days including weekends per year. Post-graduate year 2 and above are entitled to twenty-eight days including weekends per year. Vacation leave must be used during the calendar year.

#### **Sick Leave**

House officers are permitted fourteen days including weekends of paid sick leave per year that may not be accumulated into subsequent calendar years and may only be used for the illnesses of the House Officer. A call system is created for use of needed replacement for the sick House Officer which is named "Jeopardy Call". There is one upper level resident on call every day to relieve residents who are ill. The chief resident will decide if jeopardy call will be implemented depending on the need of the ill resident's service.

#### **Educational Leave**

House officers are permitted five days including weekends of education leave per year to attend or present at medical meetings that may not be accumulated into subsequent calendar years. The resident can schedule this meeting only on outpatient/ambulatory rotations and must notify the chief resident six months in advance so the schedule can be altered. The time off from the resident schedule does not affect their work schedule as it does for vacation leave.

For example, if a resident is schedule in the PER for a full month and attends a medical meeting, then that resident is still responsible for the same number of shifts as a resident who is not attending a meeting. Participating in a medical camp is counted as a medical meeting. The International Conference on Bioethics is classified as an elective, not educational leave.



**Department of Pediatrics NON-RESIDENT – GENERAL BACKGROUND INFORMATION**

This information is meant to provide some guidance to any non-resident Foreign Medical Graduate who is undergoing their Pediatric Residency at LSU Health Sciences Center on a visa or work authorization. The most important aspect of your status with LSUHSC is that you always maintain your visa status during your training program. This applies to any type of employment authorization: J1 or EAC (as an exception to policy). In addition to the standard conditions of a negative pre-employment drug screen and a valid medical license from the Louisiana State Board of Medical Examiners (LSBME), a person may NOT begin their training program prior to the start date provided on the respective authorization document, (DS-2019 or EAC) and may NOT work beyond the end date given on the authorization document. This memo is not meant to be an all-inclusive listing of the various Federal Government regulations and/or LSUHSC policies on visa issues; however, it is meant to assist you in understanding some of the important aspects of your status with us.

Important – If the actual start date is delayed beyond the official start date provided on the employment authorization, a person is not permitted to work beyond the expiration date of their original authorization unless the date officially has been extended or renewed in advance of the expiration. Visa extensions, if permitted under the applicable visa category, must be applied for well in advance of the expiration date. In the case of J-1 visas, the time period to extend a program is two to three months in advance of the current visa expiration date. For specific information on your individual case, please contact our Assistant Business Manager of Personnel, Mr. Owen Allen, 200 Henry Clay Avenue, New Orleans, LA 70118. You may contact him in person, by phone at 504-896-2143, or by e-mail at [oallen@lsuhsc.edu](mailto:oallen@lsuhsc.edu).

- 1) Insurance Coverage – Federal law requires that all J-1 personnel and their dependents have specific insurance coverage during their stay in the U.S. The minimum coverage required is: 1) medical benefits of at least \$50,000 per accident or illness, with a maximum \$500 deductible per accident or illness, 2) repatriation of remains coverage in the amount of \$7,500, and 3) coverage for any expenses associated with medical evacuation in the amount of \$10,000. (FYI, ECFMG will purchase the repatriation of remains coverage and the medical evacuation coverage once a person has been approved for sponsorship.)
- 2) Change in Status – It is strongly discouraged for an individual to travel to the U.S. in one status and then attempt to change to another status after entering the country. Very few of these requests are approved and, therefore, it is important the proper status be determined, and obtained, prior to coming to the U.S.

- 3) Important – If your visa status is J1 status, your employment is limited to established ACGME program sites for which ACGME letters of agreement are in place.
- 4) EAC (Employment Authorization) – If a non-resident (either a dependent of a person holding another visa status or someone awaiting pending approval of permanent residency status) obtains authorization to work from the INS, we can submit a request for an exception to LSUHSC policy. A non-resident is only authorized to work during the period for which the EAD is valid; therefore, an individual must ensure their EAD is renewed in time to be permitted to continue beyond the original expiration date documented on the EAD card. The lead time necessary to renew an EAD can be four to five months and, if the extension of the EAD does not arrive prior to the expiration date of the current EAD, the non-resident must discontinue work.

#### **IMPORTANT ISSUES:**

- 1) Social Security Card – If a non-resident does not yet have a social security number when that person first begins our training program, the individual may start our program pending the issuance of a SSN as long as they have passed the pre-employment drug test, have a valid medical license, and have the required work authorization documents. However, we cannot enter a person into our payroll system until a social security number (SSN) has been issued. Due to additional procedures recently implemented by the Social Security Administration whereby an individual's status is verified with Homeland Security prior to the initial issuance of a SSN, there may be additional delays in the processing of an application. In addition, after arrival in the United States, an individual must wait ten days before applying for a Social Security Card.
- 2) Change of Address Notification – Under Federal law, all non-US citizens are required to submit a change of address form online (Fm AR-11) to the U.S. Department of Homeland Security, Bureau of Citizenship & Immigration Services within ten (10) days of establishing a new address in the United States. This includes moving from one location to another within the same city.
- 3) International Travel (Visa/Passport Renewal and Travel Letters) – We do not encourage our visa personnel to travel outside of the U.S. during the course of their training; however, occasionally this is unavoidable. Therefore, if a trip outside of the country is planned during the course of a non-resident's stay in the U.S., it is their responsibility to make certain that sufficient advance notification of the intended travel is given in order that the travel request is processed in a timely manner by the respective office. Should it be necessary to renew a visa or passport prior to re-entry into the U.S., the visa and/or passport **MUST** be renewed before an individual returns to the U.S. Upon return to the U.S., a copy of the **FRONT** and **BACK** of the **new I-94** and the new visa/passport, if applicable, must be provided to Mr. Allen for forwarding onto the International Services Office. For J-1 visa personnel, please contact Mr. Allen and he will request a "letter of good standing" from ECFMG and also request that they update the SEVIS System.

For H-1B personnel, Mr. Allen will coordinate the generation of the requisite letter from the LSUHSC Governmental Programs Office.

Invitation for Family/Relatives Visit (obtain visitor's visa) – If you are interested in having a family member visit, all immigration-related correspondence must be issued from the LSUHSC Governmental Programs Office. Before a letter requesting a visitor's visa can be issued, the following information must be provided to Mr. Allen:

- a) Exact name(s) – Last name in CAPITAL LETTERS, first name, middle name
  - b) Relationship
  - c) Date of birth
  - d) City and country of birth
  - e) Citizenship
  - f) Dates of expected visit
- 4) Licensure – It is the individual's responsibility to always maintain a valid medical license from the Louisiana State Board of Medical Examiners (LSBME). Should a situation develop whereby medical licensure has not been renewed in a timely manner, the individual will be placed on leave of absence (without pay) until proof has been obtained from LSBME that the individual possesses a valid medical license. FYI: the LSBME requires successful completion of USLME Step 3 before issuing a renewal GETP beyond the first 24 months of training. If the FMG is applying for unrestricted licensure, completion of the FCVS profile through the Federation of State Medical Boards (FSMB) is also required.

**POLICY ON ~ PROCEDURE AND CASE LOGS**

1. All residents must keep a record of procedures performed and continuity clinic patients visits during their residency online at [www.acgme.org](http://www.acgme.org)
2. Each procedure should be recorded with a medical record number, date, and location the procedure was performed. It should also include who supervised the procedure and how well the resident performed the procedure.
3. A minimum number of procedures are required of PGY-1's: 5 attempts at lumbar puncture and intubation with 3 successful. A mandatory minimum number of attendance at 12 newborn deliveries is required of all PGY-1's and 5 for PGY-3's.
4. There are three categories of procedures:
  - Procedures tracked until competent
    - Arterial puncture
    - Bladder catheterization
    - Placement of IV line
    - Reduction & splinting of simple dislocation
    - Suturing of laceration
    - Venipuncture
  - Procedures tracked throughout residency
    - Endotracheal intubation
    - Lumbar puncture
    - Umbilical artery catheter placement
    - Umbilical vein catheter placement
  - Additional procedures
    - Circumcision
    - Gynecological evaluation
    - Developmental screening test
    - Incision and drainage of abscess
    - Any other procedure
    - (a list of other Additional Procedures can be found at [www.ACGME.org](http://www.ACGME.org))
5. All patients seen in continuity clinic must be logged into the case log system. All information requested, such as age, gender, date of visit and diagnosis code must be entered. Residents must see progressive number of patients, with a minimum of 3 patients for PGY-1's, 4 for PGY-2's, and 5 for PGY-3's and all must attend 36 half day clinics/year.



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## POLICY ON ~ PROFESSIONALISM

### Professionalism Score

In addition to clinical competency evaluations, residents will also receive ratings of their professional conduct. Residents must demonstrate a commitment to carrying out professional responsibilities and adherence to ethical principles. They are expected to adhere to all of the rules and regulations of the ACGME, LSUHSC, and the Department of Pediatrics Residency Program. This includes documentation of numerous educational and clinical activities.

Each resident will be granted **100 Professionalism points** on a quarterly basis based on the criteria listed below. For each criterion that is NOT MET, points will be subtracted. If a resident's score is **less than or equal to 80, a warning will be issued**. If a resident **scores less than or equal to 80 on two quarters** in one calendar year, the resident will be **reported to the American Board of Pediatrics Annual Tracking System** as "Unprofessional". Each resident's progress will be monitored and recorded every month.

Criteria	Points
Satisfactory evaluations from faculty members (a score of 2 or above on all parts of the professionalism domain of the monthly rotation evaluation)	10
Satisfactory evaluations from peers (a score of 2 or above on all parts of the professionalism domain of the monthly rotation evaluation)	10
Satisfactory evaluations from medical student evaluations (a score of 3 or above on "Treats medical students with courtesy and respect")	10
Satisfactory evaluations from nurse evaluations (ratings of satisfactory or outstanding)	10
Satisfactory evaluations from patient evaluations (ratings of 3 or above in the professional category)	10
Satisfactory reports from unsolicited sources (patients, families, hospital or department personnel including chief residents)	10
Up to date documentation of the required number of continuity clinics (3 per month) and patient visits (PGY-1, 3; PGY-2, 4; PGY-3, 5) on the ACGME website	10
Daily documentation of Duty hours on New Innovations	10
Attendance of the required number of educational conferences	10
Completion of 20 PREP questions per month, board review exam or take-home quiz, observed history and physical examination (for PGY-1 only), LSUHSC GME and Compliance Modules	10
Professional Total Score	100

Note: if multiple unsatisfactory evaluations from the same category of sources are reported in one quarter, the program may subtract "10" points for each evaluation.

### **Reporting to the American Board of Pediatrics (ABP)**

An annual tracking system is conducted by the ABP in which the program director must submit a clinical competency rating and a professionalism rating. The clinical competency rating is based on the evaluations from faculty. Ratings for professionalism will be based on the professionalism scoring system as described above. If an unsatisfactory evaluation (score less than or equal to 80) is given for two quarters for professionalism, this will be reported on this annual tracking system. According to the ABP rules, a resident or fellow who receives an unsatisfactory evaluation for

professionalism receives no credit for that year of training unless the program director provides evidence as to why a period of observation rather than a repeat year of training should be completed.

### **Termination, non-reappointment, summary suspension, and other adverse action**

A resident may be dismissed or other adverse action may be taken for cause, including but not limited to: i) acts of moral turpitude; ii) revocation, expiration or suspension of license; iii) insubordination; iv) conduct that is detrimental to patient care; or v) any unprofessional conduct that is deemed significant by the program director, or head of the department or designee.

### **Referral to Campus Assistance Program**

The program will refer residents to the LSUHSC Campus Assistance Program if a personal or work related problem is interfering with their job performance. Depending on the nature and severity of the problem this may be an administrative (mandated) or voluntary referral.

### **Assignment of Additional Clinical Duties**

Residents will be assigned to additional weekend night float coverage when the appropriate completion and documentation of educational and clinical activities has not been performed on the following timeline:

QUARTERLY attendance of required conferences; (e.g. every three months a resident's total number of hours of attendance is calculated. If this does not meet the expected number of hours, 10 points will be subtracted.)

BIANNUAL completion of observed history and physical examination for PGY-1's.

ANNUAL completion of LSUHSC Compliance and GME modules and for PGY-1's, sitting for USLME Step 3.

MONTHLY documentation of: Continuity clinic patient visits on the ACGME website, Duty hours on New Innovations, 20 PREP questions, and Board review quiz (either during session or as a take home quiz).

With regard to activities requiring monthly documentation, each academic year residents will be allowed one month of non-compliance in order to account for personal difficulties, busy workload months, etc. No such allowances will be made for the required quarterly, biannual and annual activities. If there is a scheduling conflict with night float coverage, a resident may be assigned night call in the PICU or note float as a substitute at the discretion of the program director.



Department of  
Pediatrics

## **POLICY ON ~ REQUIRED SUBSPECIALTY EXPERIENCE**

Residents must complete a minimum of 7 months during the 3 years in subspecialty training. A minimum of four different 1-month block rotations must be taken from the following list of pediatric subspecialties:

- Allergy/Immunology
- Infectious Diseases
- Cardiology
- Nephrology
- Endocrinology
- Genetics
- GI/Nutrition
- Hematology-Oncology
- Pulmonary
- Rheumatology
- Child Abuse

Additional subspecialty experiences to comply with the minimum of 6 months may be scheduled from the list above or from the following list:

- Child Psychiatry
- Dermatology
- Ophthalmology
- Orthopedics & sports medicine
- ENT
- Pediatric surgery
- Pediatric radiology

Two subspecialty areas from this list may be combined over a 1 or 2 month period.

All first year residents and upper level residents who perform below the national average on the Annual American Board of Pediatrics In-Training examination can only choose subspecialty rotations from the first list.

### Credit for inpatient rotations

For the inpatient hematology-oncology rotation, residents will receive one month credit since the entire month is dedicated to one subspecialty. For the silver team rotation, residents will receive 3 weeks credit, one each for renal, pulmonary, and cardiology. Two weeks of subspecialty credit will be given for the gold team for neurology (1 week) and gastroenterology (1 week). Note this credit will be given only

once, i.e. if a resident rotates twice on silver team over the three years of residency, they will only receive subspecialty credit once.



**Department of Pediatrics POLICY ON ~ RESIDENT DUTY HOURS**

The Department of Pediatrics Residency Program provides residents with a sound academic and clinical education that is carefully planned and balanced with concerns for patient safety and resident well-being. The program ensures that the learning objectives are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education is a priority in the allotment of residents' time and energies. Duty hour assignments recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

**I. DUTY HOURS**

**1. Duty Hours**

- a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours will be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and moonlighting.
- c. Residents will be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- d. Duty periods of PGY-1 residents will not exceed 16 hours in duration.
- e. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Residents may be allowed to remain on-site in order to accomplish effective transitions of patient care; however, this period of time must be no longer than an additional four hours.
- f. Adequate time for rest and personal activities will be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call and must consist of an 8-hour time period between duty periods. After a 24-hour shift, residents must have at least 14 hours off before their next scheduled duty period.

**2. On-Call Activities**

- a. In-house call will not occur no more frequently than every third night, averaged over a four-week period. For ICU rotations, residents will take every 4th night call. During outpatient rotations as an upper level, residents may be assigned 1-3 cross covers per month. Interns will not

participate in overnight call. For the emergency room rotations, residents will work 16 shifts per month.

- b. Continuous on-site duty, including in-house call, will not exceed 24 consecutive hours. Residents may remain on duty for up to four additional hours to participate in didactic activities, transfer care of patients, and maintain continuity of medical care.
  - 1. Examples of work schedules: If the resident's workday starts at 9:00am, they must leave by 1:00 pm post call. If the workday starts at 8:00am, they must leave by 12:00 pm post call. If the workday starts at 7:00 am, they must leave by 11:00 am post call.
- c. No new patients will be accepted after 24 hours of continuous duty.
- d. At-home call (pager call) is defined as call taken from outside the assigned institution. LSU Pediatric residents do not participate in home call.

## II. EDUCATION, ALERTNESS MANAGEMENT AND FATIGUE MITIGATION POLICY

The program is committed to and is responsible for promoting patient safety and resident well-being in a supportive environment.

- A. Faculty members are informed of the ACGME duty hour rules and also receive education on the signs of sleep deprivation, alertness management and fatigue mitigation through a variety of educational sessions: 1) annually at a faculty meeting, 2) as part of the educational section of department's quarterly newsletter, and 3) at the end of the year jeopardy quiz game. If a faculty member is concerned that a resident is not fit for duty due to fatigue or illness or any cause, they will immediately report this to the program director.
- B. Residents are also informed of the ACGME duty hour rules and receive similar education on the signs of sleep deprivation, alertness management and fatigue mitigation through a variety of educational sources: 1) LSUHSC core modules, 2) annually at intern retreat, 3) quarterly department newsletter and 4) the end of the year jeopardy quiz game.
- C. Residents are provided call rooms with beds in a quiet area away from patient care to rest. Napping is encouraged for the residents who are required to work overnight during the hours of 10 pm to 8 am to minimize the effects of sleep deprivation. If a resident feels that fatigue is affecting patient care, they should call the chief residents and a backup (or jeopardy) resident will be called to take their place. (See E below.)
- D. If a resident should feel that fatigue may affect patient care or their transportation home, they may access the call rooms at any time for rest.
- E. Back up Call Policy: If a resident cannot perform their required duties, they must contact their supervising faculty member and the chief residents. A call system is

created for use of needed replacement for the House Officer who is unable to perform their duties which is named Jeopardy Call. The Jeopardy Call schedule is created by the chief residents and distributed with the monthly call schedule. There is one upper level resident on Jeopardy Call every day as back up. The chief residents will determine if Jeopardy Call needs to be activated depending on the need of the residents' service or their responsibilities. The chief residents are responsible for notifying the Jeopardy Call Resident to report to duty. The coordinator is also notified by the chief residents for proper documentation and monitoring of sick days.

### III. MONITORING OF DUTY HOURS AND HOUSE CALL

- A. To ensure compliance with duty hour regulations put forth by the ACGME, all residents are required to log all duty hours in New Innovations. Residents who fail to log duty hours or log erroneous duty hours are subject to disciplinary action by the program.
- a. The logged duty hours are reviewed monthly by the Compliance Committee.
  - b. The report includes:
    - i. Number of hours on duty per resident per week averaged over a 4-week period.
    - ii. Number of days per week of in house call for the upper level residents averaged over a 4-week period.
    - iii. Maximum number of continuous hours worked by any resident
      1. Number of instances that interns worked over 16 hours and upper level residents worked over 28 hours.
    - iv. Number of days free from clinical duty over the 4 week period.
    - v. Shortest number of hours free from duty between shifts for each resident.
  - c. Any violation of the ACGME mandated duty hours is investigated. If there are any problems that are seen as consistent or in need of intervention, the Residency Review Committee will take the appropriate action.
  - d. Residents also have the option to anonymously report any violations via the LSU duty hours hotline at 504-599-1161.
- B. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period to provide care to a single patient. Examples of this would be required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. The resident must hand over the care of all other patients to the oncoming team or resident. The resident must provide the program director a written report describing this situation. The program director will track these episodes of additional duty.

#### IV. NIGHT FLOAT POLICY

- A. The night float system provides nighttime coverage for the four inpatient ward teams and occurs in two separate blocks: weekday night float occurring from Monday to Thursday night (4 nights in a row) and weekend night float occurring from Friday to Sunday night (3 nights in a row). Residents are never scheduled for more than 4 consecutive nights of night float. Weekday night float occurs in ½ month blocks whereas weekend night float may occur as an isolated weekend or two consecutive weekends. Residents are scheduled for 1-2 weekends of night float/month while on outpatient rotation months except for call free months. There are at least two senior residents and one to two interns on night float at a given time to cover the four ward teams.
- B. Check-out between the day team and the night float team occurs promptly at 6:30pm. Each ward team has a separate and consistent admit and floor call pager. Admit pagers are to be carried by the senior resident, and the floor pager is carried by either the senior or junior resident assigned to the team for the night. Patient lists should be accurately updated each day by both the day and night teams. Check-out to the day team occurs at 6:30 am, after which the night float residents are free of all other clinical duties (residents are free of all clinical duties both the day before their first night float shift and the day after their last shift).
- C. Educational requirements: While on a two week night float block, each group is required to prepare a morning report case presentation and attend night float rounds with one of the faculty and chief residents. This is to ensure that learning is not compromised while working only at night, and to receive feedback regarding decisions that were made during the night. Residents must contact the attending with each admit to receive adequate feedback and learning.

#### V. TRANSITIONS IN CARE

- A. Each ward team will conduct a structured handoff session of patient information at least twice each 24-hour period. This will occur when the day team signs out to the night float team in the evening and again when the night float team signs out to the day team in the morning.
- B. Each patient must be entered into a comprehensive patient list which includes but is not limited to patient identifiers, weight, diagnoses, medications, allergies, pending labs or consults, new or anticipated problems, attending physician and guardian contact information, and resuscitation status (DNR) if applicable. The senior-most resident on the team is responsible for assuring the accuracy of this list on each shift. In addition, verbal face-to-face handoff will be conducted in an area where

interruptions are less likely (resident lounge or conference room). The patient list is used as an adjunct to verbal handoff and as a reference throughout the shift. To minimize interruptions, a protocol has been adopted by both the hospital nursing staff and the residency program where pages to residents and are minimized during hand off times.

- C. Residents are trained annually on techniques for effective handoff and communication. This training occurs with an interactive session conducted by the program director.
- D. Residents complete written evaluations assessing the handoff performance of their peers at the end of each night float block. Any concerning evaluations are investigated by the chief residents or program director. Also, if a grossly insufficient handoff occurs, the recipient is required to bring a copy of the patient list along with specific complaints to the chief residents. Direct feedback is then given to the resident with insufficient performance by the chief residents and program director.
- E. Contact information for each attending physician is kept on the aforementioned list as well as with the hospital operator. Residents may at any time contact the hospital operator to find out which attending physician is on call for each service.
- F. If signs of excessive fatigue in the outgoing team are noted by the residents of the oncoming team, the chief residents should be notified immediately. Anyone who appears to be excessively fatigued will be immediately relieved of their duties and encouraged to nap in the call room prior to leaving the hospital.
- G. Two members of each four-person team are required to remain in the hospital to conduct handoff to the night float team each evening, thereby reducing the number of handoffs during the day. Also, any resident who is assigned to afternoon continuity clinic will not return to the hospital to handoff patients to the night team; two other members of the team must remain in the hospital instead. This, again, is to reduce the number of transitions and to have the most knowledgeable team members conduct handoff to the night team.
- H. The call schedule for individual residents is available online, with the hospital operator, and on each nursing unit at all times. Each team also has a “team pager” so that if any medical personnel are unsure which resident is responsible for the patient, the team may be reached easily by this route.

## VI. LINE OF SUPERVISION POLICY

Appropriate supervision of residents must be provided by qualified physicians to assure the provision of safe and effective care of patients. Every patient will have an identifiable attending which is clearly marked on the patient's medical record that is ultimately responsible for that patient's care. The contact information (pager, home phone, cell phone numbers, and/or answering service) and call schedule for every attending is available at the Children's Hospital Information/Operator Desk 24/7. Every attending is appropriately credentialed and privileged by each institution based on the Joint Commission of Hospital Accreditation Standards.

### **PGY-1**

PGY-1 residents must be supervised by junior and senior residents, fellows and the attending physician. History and Physicals performed by interns must be reviewed and co-signed by their supervising junior or senior resident and the attending physician. All patients followed by interns are to be examined daily by the junior or senior resident and/or the attending physician.

### **PGY-2, 3, 4 (Intermediate and Senior Residents)**

Junior and Senior residents must be supervised by the attending physician. All progress notes and History and Physicals are to be reviewed and signed by the attending physician. For all new patients, the resident must discuss the patient's condition, diagnosis and plan for treatment with the attending physician or fellow. This may be either by directly speaking with the faculty/fellow when in house or via phone with the faculty/fellow. Residents must notify the fellow or attending physician when a patient develops an unexpected problem, if a patient's status or condition worsens, if a PACT team is called or if a patient is transferred to the intensive care unit. Residents should contact the attending physician whenever they are uncomfortable with the patient's status or management plan. Documentation of this process on admit history and physicals, in the progress note section of the chart, and on PACT team consultation sheets is required and provides a mechanism for monitoring.

### **Chief Residents**

The chief residents are a liaison between the residents and the faculty. If any conflicts arise between the residents and faculty, the chief residents should be notified. The chief residents are responsible for contacting the Program Director. The residents may contact the Program Director of any problems that are unresolved by the chief residents.

### **Faculty/Attending Physicians**

The attending physicians are ultimately responsible for all patient care. They must examine and oversee all aspects of the patient's care on a daily basis. All admission history and physicals, daily progress notes, and discharge summaries must be authenticated by the attending physician. Fellows under the direction of the supervising attending may respond and direct the care of patients, but the attending must be kept abreast of any critical situations where the potential for an unexpected outcome is possible. The attending physicians must be available at all times, 24 hours, 7 days a week for resident supervision.

### **Prevent a Code Team (PACT)**

All Children's Hospital healthcare providers including residents and attending physicians should request urgent medical consultation for a patient perceived to be in medical distress via the PACT system. This will provide the timely assessment of potentially critically ill patients by the PICU staff (PICU respiratory therapist, nurse and resident who must contact the PICU attending physician on call). Consultation with the patient's attending physician by the resident is required after the PACT consultation.

### **Safety Issues**

If there is significant concern regarding the quality of patient care, the residents and /or attending physicians should complete a Children's Hospital QA/I Safety Report. Based on its analysis of the severity of harm ranging from no harm to death, a response ranging from aggregating the data to an intense assessment and root cause analysis is performed. If a resident disagrees with an action of the supervisory fellow, they should voice their concern to the fellow. If the concern is not addressed to the satisfaction of the resident they should contact the attending physician. If a resident disagrees with an action of the attending physician, they should voice their concern to the attending physician. If the circumstances or events have the capacity to cause harm to a patient and the concern is not addressed, the resident should utilize the ASAP hotline which is investigated by the QA/I Department. The residents may also utilize other resources such as the chief residents and subspecialty faculty for consultations and assistance in patient care in times of disagreements with attending physicians.

If any health care provider has a concern regarding the quality of care delivered by a resident physician, they should voice their concern to this resident. If the concern is not addressed satisfactorily, then the health care provider should ask their supervisor for an opinion of the situation. If the supervisor is in agreement that there is a safety concern, they should contact the attending physician.

### **Program Director**

The program director is responsible for responding to any trends or re-occurring concerns in regards to patient safety issues involving residents/fellows or attending physicians. The Program Director will address this issue with the resident. The Program Director will notify the Chair for any issues related to the LSUHSC faculty members and will

report to the medical director of Children's Hospital for issues related to hospital operations or medical staff members who are non members of the LSUHSC faculty.

### **Chair**

The Chair of the Department of Pediatrics will receive the annual summary reports on the residents' evaluations of all of the faculty members. He/she is responsible for providing feedback to the faculty members on their performance.

### **Patients/families**

All residents and faculty are expected to introduce themselves to their patients and inform them of their role in their care. For inpatients, these roles are emphasized during daily rounds that typically involve all caregivers for the patient. In addition, patients admitted to the hospital wear wristbands that include the name of their attending physician. Patient/Parent identification of attending physicians is monitored by Children's Hospital via patient/parent surveys. Numerous published studies have indicated that only 20-25% of inpatients are able to identify the attending physician of record by name. Based on the surveys received by Children's Hospital, our numbers fall at or above these nationally published percentages. In the outpatient setting, patients are given appointments with a designated attending physician (rather than a department) and residents working with that attending are expected to disclose their role in the patient's care in all outpatient settings. Since all outpatients are seen by an attending, in addition to the resident (when present), there should not be no confusion with regard to their respective roles in patient care.

**Table of Supervision by PGY level**

<u>PGY</u>	<u>Direct by Faculty</u>	<u>Direct by senior residents</u>	<u>Indirect but immediately available - faculty</u>	<u>Indirect but immediately available - residents</u>	<u>Indirect available</u>	<u>Oversight</u>
<u>I</u>	During rounds/clinic	During rounds	During the day by attending physician with 24 in house ER coverage	24 hours/day 7 days/week	24 hours/day 7 days/week	24 hours/day 7 days/week
<u>II</u>	During rounds/clinic	N/A	During the day by attending physician with 24 in house ER coverage	24 hours/day 7days/week (PICU resident in house 24 hours/day for backup)	24 hours/day 7 days/week	24 hours/day 7 days/week
<u>III</u>	During rounds/clinic	N/A	During the day by attending physician with 24 in house ER coverage	24 hours/day 7days/week (PICU resident in house 24 hours/day for backup)	24 hours/day 7 days/week	24 hours/day 7 days/week
<u>IV</u>	During rounds/clinic	N/A	During the day by attending physician with 24 in house ER coverage	24 hours/day 7days/week (PICU resident in house 24 hours/day for backup)	24 hours/day 7 days/week	24 hours/day 7 days/week

Definitions of various levels of supervision:

- a. Direct Supervision – the supervising physician is physically present with the resident and patient.
- b. Indirect Supervision:
  - 1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
  - 2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- c. Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.



**Department of Pediatrics PGY-1 PROMOTION CRITERIA**

Residents’ performance will be reviewed for promotion on a yearly basis by the Competency Committee. The members shall use various evaluation tools including rotation evaluations, in-training examinations, 360 degree evaluations and any other pertinent information to decide on the promotion of a given resident to the next year of training and/or graduation.

**For a resident to be promoted to PGY-2 all criteria must be satisfied.**

Pass	Fail	Criteria
		Satisfactory performance on all evaluations by faculty. Definition of Satisfaction = should achieve satisfactory performance on each component (score of 2 or above). If fails, see below.*
		USLME – Must sit for step III
		Minimum number of procedures: 5 attempts at LP and intubation with 3 successful. Attendance at 12 deliveries.

\*Reason for failure – Check one:

- Unsatisfactory performance on 2 rotations – no promotion
- Unsatisfactory performance on 1 rotation – remediation work before promotion

**Educational Didactic Sessions:**

All PGY-1 residents must attend 150 hours of educational conferences (morning report, noon conference, grand rounds, clinical case conference, and professional sessions).

If a resident fails to meet this goal, they must complete additional PREP questions based on the number of lectures that are missed at a 1:2 ratio. For example: If a resident attends only 140 lectures and is missing 10 lectures, then they must complete 20 additional PREP questions. These PREP questions must be completed by July 31<sup>st</sup> of their PGY-2 year.

## PGY-2 PROMOTION CRITERIA

Residents' performance will be reviewed for promotion on a yearly basis by the Competency Committee. The members shall use various evaluation tools including rotation evaluations, in-training examinations, 360 degree evaluations and any other pertinent information to decide on the promotion of a given resident to the next year of training and/or graduation.

**For a resident to be promoted to PGY-3 all criteria must be satisfied.**

Pass	Fail	Criteria
		Satisfactory performance on all evaluations by faculty. Definition of Satisfaction = should achieve satisfactory performance on each component (score of 2 or above). If fails, see below.*
		Presentation at one Clinical Case Conference
		USLME – Step III Pass

\*Reason for failure – Check one:

- \_\_\_\_\_ Unsatisfactory performance on 2 rotations – no promotion  
 \_\_\_\_\_ Unsatisfactory performance on 1 rotation – remediation work before promotion

### **Educational Didactic Sessions:**

The required attendance is based on the resident's performance on the ABP ITE of their second year. All PGY-2 residents who score at or above the national average must attend 125 hours of educational conferences (morning report, noon conference, grand rounds, clinical case conference, and professional sessions). All PGY-2 residents who score below the national average must attend 150 hours of educational conferences. Because the results of the exam are not released until October, the resident should plan accordingly to meet these requirements (i.e. if they performed poorly on the first year's ABP ITE, then they should attend enough conferences in July, August, and September to meet the goal of 150 hours.) If a resident misses the exam due to medical leave, the requirements will be based on the previous year's performance.

If a resident fails to meet this goal, this will be reflected in their professionalism score (refer to Professionalism section). In addition, they must complete additional PREP questions based on the number of lectures that are missed at a 1:2 ratio. For example: If a resident attends only 140 lectures and is missing 10 lectures, then they must complete 20 additional PREP questions. These PREP questions must be completed by July 31<sup>st</sup> of their PGY-3 year.

### PGY-3 PROMOTION CRITERIA

Residents' performance will be reviewed for promotion on a yearly basis by the Competency Committee. The members shall use various evaluation tools including rotation evaluations, in-training examinations, 360 degree evaluations and any other pertinent information to decide on the promotion of a given resident to the next year of training and/or graduation.

**For a resident to graduate all criteria must be satisfied.**

Pass	Fail	Criteria
		Satisfactory performance on all evaluations by faculty. Definition of Satisfaction = should achieve satisfactory performance on each component (score of 2 or above). If fails, see below.*
		Participation in Practice Based Learning Improvement Project
		Presentation at one Clinical Case Conference
		EBM presentation
		Procedures: attend 5 deliveries during NICU rotation

\*Reason for failure – Check one:

- \_\_\_\_\_ Unsatisfactory performance on 2 rotations – no promotion  
 \_\_\_\_\_ Unsatisfactory performance on 1 rotation – remediation work before promotion

#### Educational Didactic Sessions:

The required attendance is based on the resident's performance on the ABP ITE. All PGY-3 residents who score at or above the national average must attend 100 hours of educational conferences (morning report, noon conference, grand rounds, clinical case conference, and professional sessions). All PGY-3 residents who score below the national average must attend 150 hours of educational conferences. Because the results of the exam are not released until October, the resident should plan accordingly to meet these requirements (i.e. if they performed poorly on the first and second year's ABP ITE, then they should attend enough conferences in July, August, and September to meet the goal of 150 hours.) If a resident misses the exam due to medical leave, the requirements will be based on the previous year's performance.

If a resident does not meet these requirements by the completion of their third year, this will be reported to the American Board of Pediatrics as an unsatisfactory performance in the professionalism category which will jeopardize their board eligibility (refer to Professionalism section).